the Journal
MICHIGAN
STATE MEDICAL SOCIETY
MAY, 1960 • VOLUME 59 • NUMBER 5

Chinese Symbol
For LONGEVITY

Aging . . . with zest, skill, experience, enthusiasm

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Herbert Hoover
Eleanor Roosevelt
Winston Churchill
Douglas MacArthur
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LITERATURE SUPPLYING DETAILS OF DOSAGE AND ADMINISTRATION AVAILABLE ON REQUEST.

Bibliography: *(1) Maltby, G. L.:* J. Maine M. A. **48**:*257, 1957. (2) Bray, P.F.:* Pediatrics **23**:*151, 1959.*

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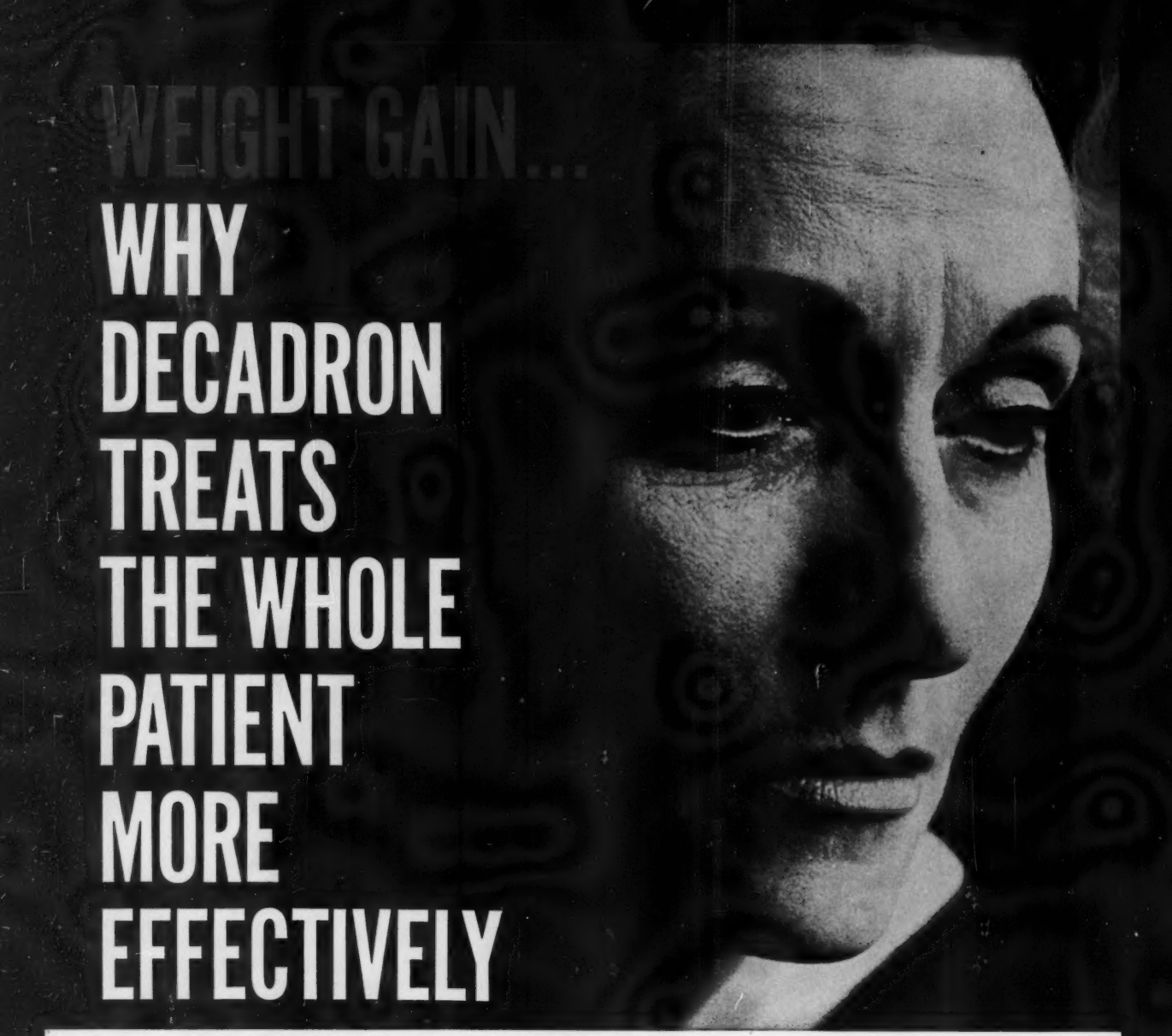

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References: 1. Bunim, J. J., et al.: Arthritis & Rheumatism *1*:313, 1958. 2. Silverman, H. I., and Urdang, A.: Am. Prof. Pharm. *25*:531, 1959. 3. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy *17*:710, 1959. 4. Spies, T. D., et al.: South. M. J. *51*:1066, 1958. 5. Galli, T., and Mannetti, C.: Minerva med. *50*:949, 1959. 6. Segal, M. S., et al.: Ann. Allergy *17*:413, 1959. 7. Duvenci, J., et al.: Ann. Allergy *17*:695, 1959.

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May, 1960

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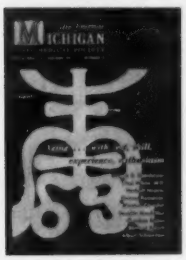

THE COVER

For this Aging number, Artist Dirk Gringhuis combines the Chinese symbol for "Longevity" with appropriate copy for an effective cover, stressing "Aging . . . with zest, skill, experience, enthusiasm."

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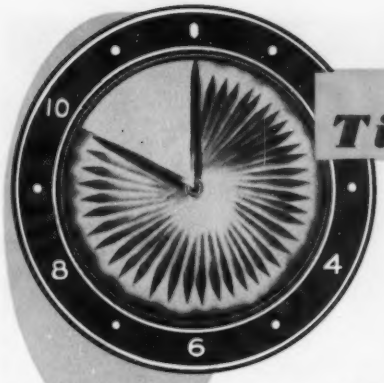

6-10 HOURS SUSTAINED THERAPY

ONE *and only* ONE *Timed* AMO*dex* CAPSULE PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

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- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
- CLINICALLY ECONOMICAL TO THE PATIENT

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Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
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Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

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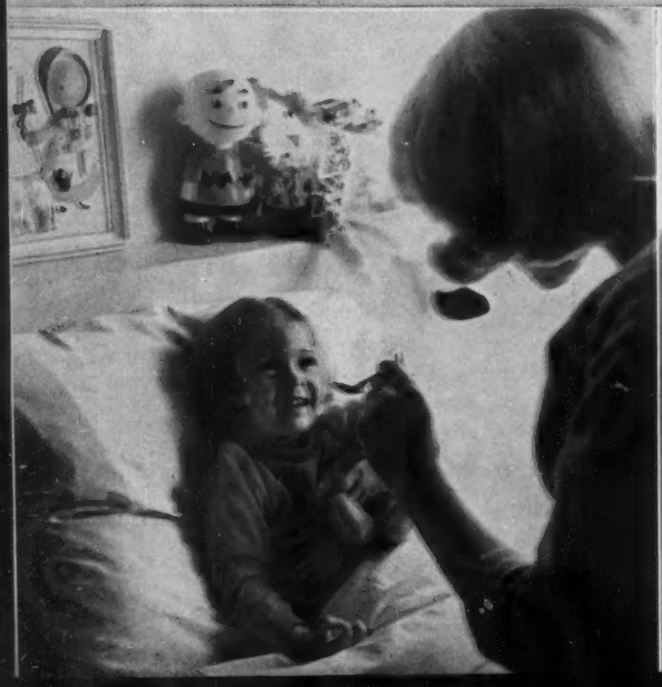

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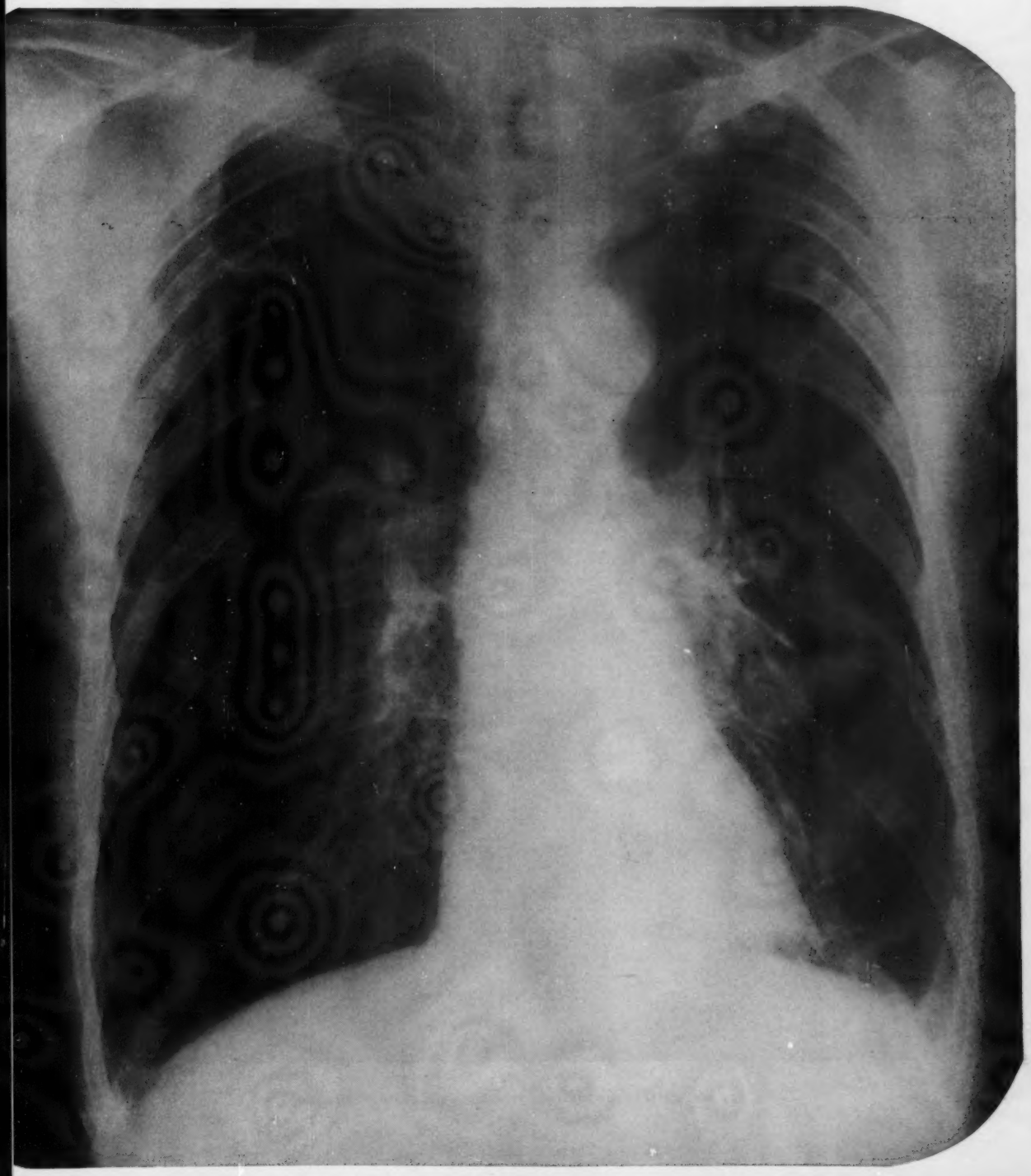

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relief comes fast and comfortably

– does not produce autonomic side reactions

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Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked*, coated tablets.

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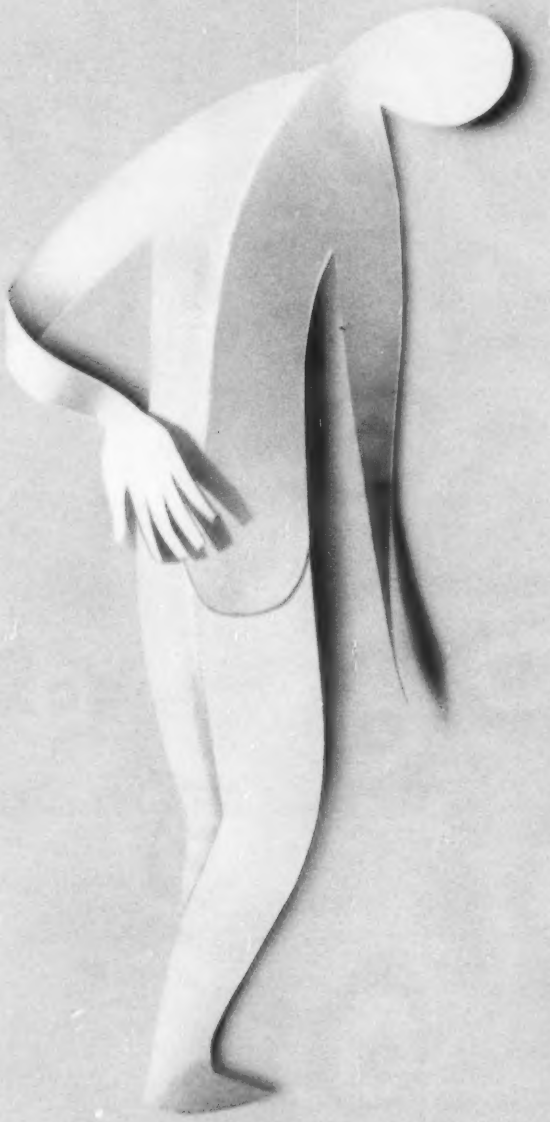

relieves both stiffness and pain with safety... sustained effect

In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

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*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

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Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

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WALLACE LABORATORIES, New Brunswick, New Jersey


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ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

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PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

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ALPEN

ALPEN™—potassium phenethicillin

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when sulfa is your plan of therapy... KYNEX is your drug of choice

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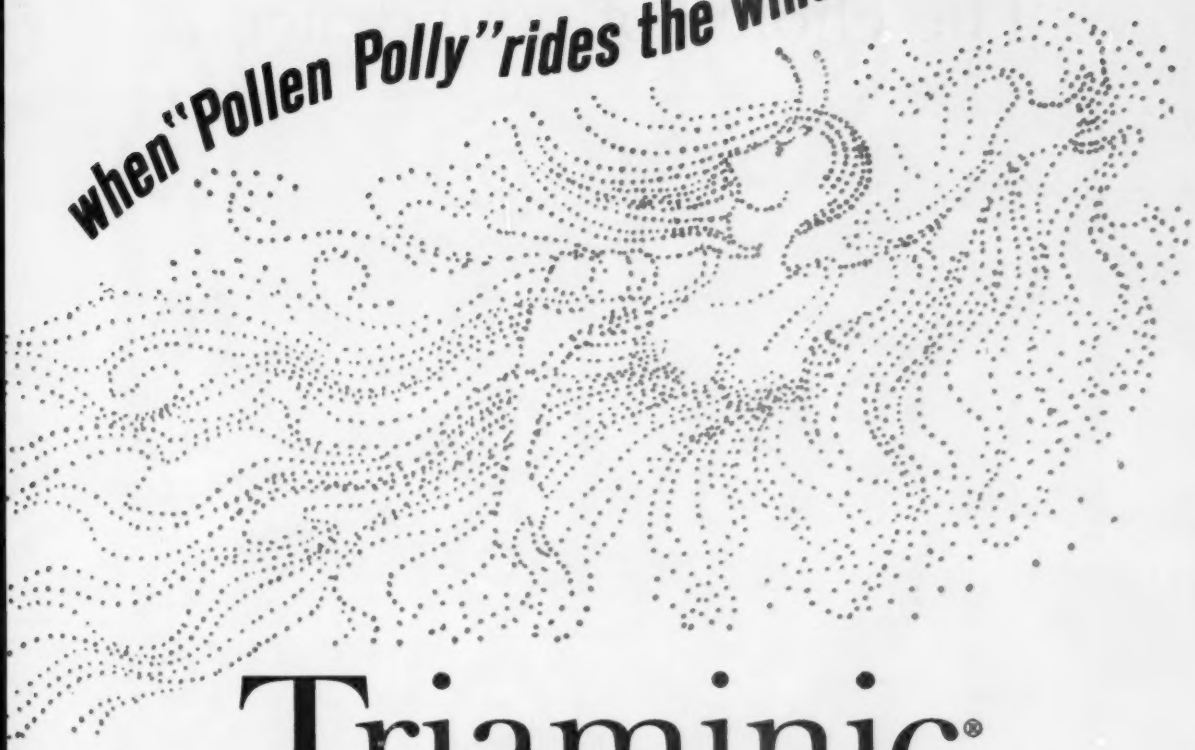

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The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

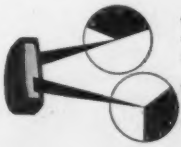
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Malien, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

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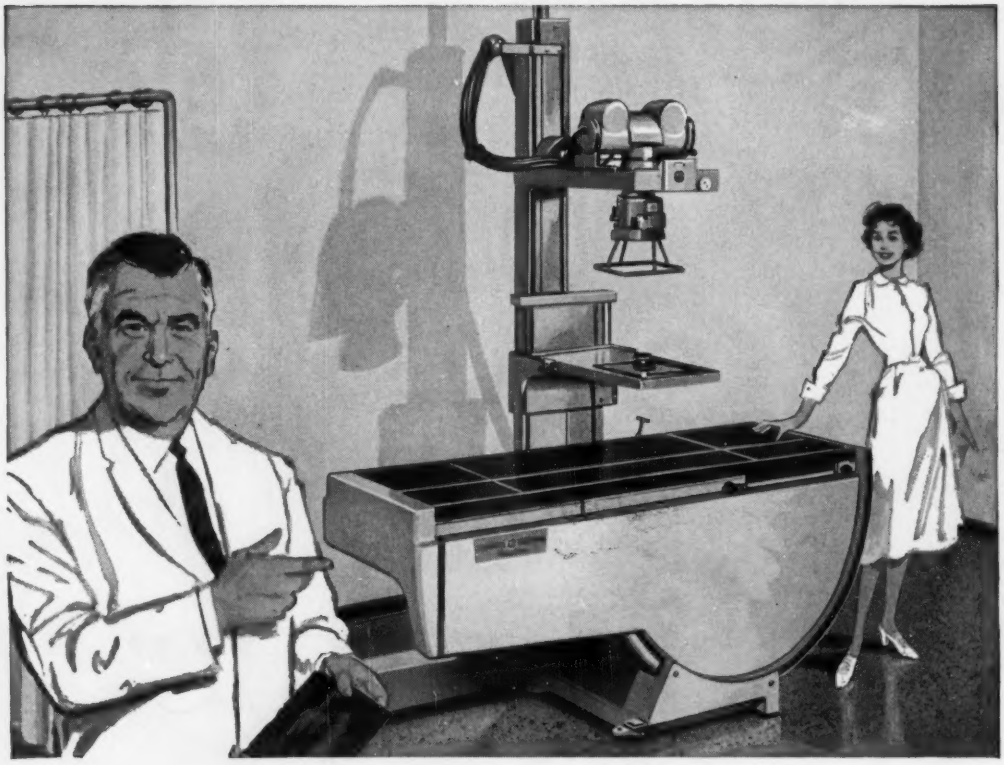

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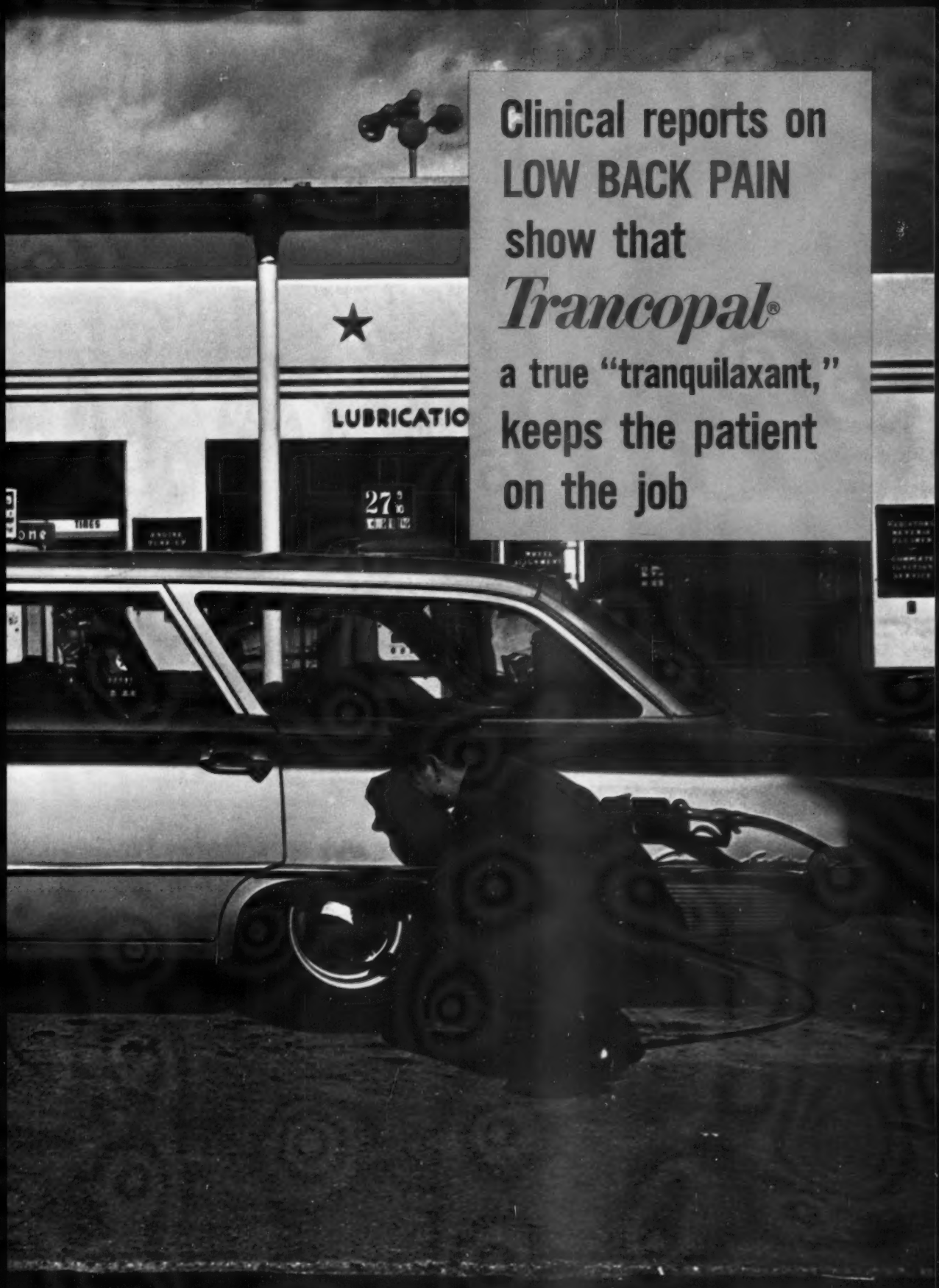
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LOW BACK PAIN
show that
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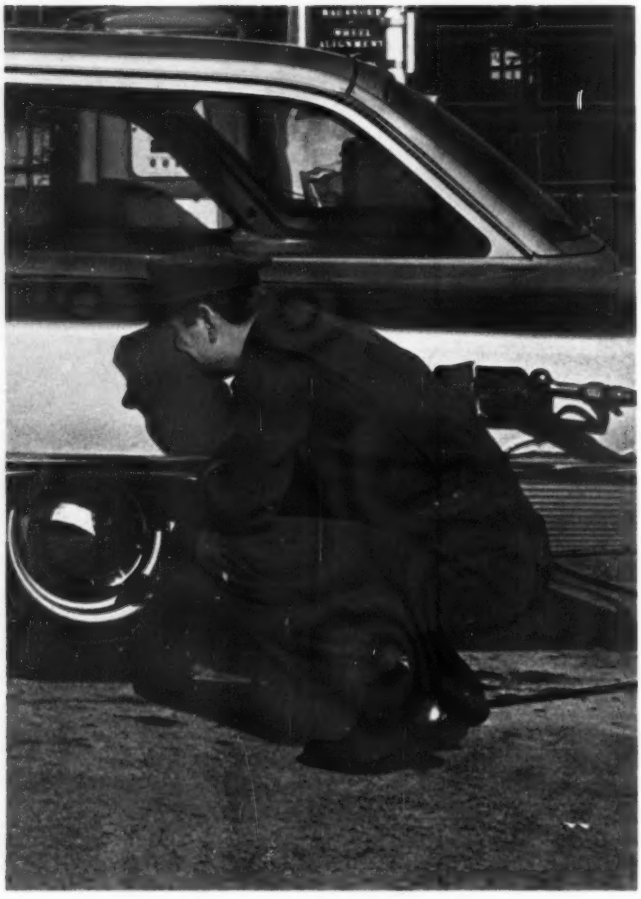

relaxes skeletal muscle spasm so the patient can continue to work

Clinical experience shows that Trancopal will enable your patients with low back pain to keep going strong. Lichtman[1] reports that 310 of his 331 patients treated with Trancopal obtained satisfactory relief. These patients were suffering from low back pain, stiff neck, postoperative muscle spasm or other skeletal muscle spasms associated with trauma, bursitis, osteoarthritis and rheumatoid arthritis. Mullin and Epifano[2] reported that Trancopal brought relief to all of 39 patients with skeletal muscle spasm. In these patients, who had suffered from trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome, the effect of Trancopal was ". . . excellent and prompt . . ."[2] Gruenberg[3] obtained marked relief with Trancopal in 258 of 304 patients with low back pain, torticollis, arthritis and other conditions associated with skeletal muscle spasm. Moderate relief was obtained in an additional group of 28 patients. Trancopal is a true "tranquilaxant" because "It combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[4] Side effects have been few and minor — and in no case were they serious enough to warrant discontinuing the use of Trancopal.[1] "Trancopal is exceptionally safe for clinical use."[3]

relieves anxiety and tension so the patient can carry on

Trancopal is also an effective agent for patients in anxiety and tension states. According to recent clinical reports,[1,5] it calms the patients but allows them to continue their work or other activity. Indeed, Lichtman found that his patients with anxiety ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted . . ."[1] He observed that Trancopal brought good to excellent relief to 114 of 120 patients in anxiety states. Ganz,[5] who noted good to excellent relief in 32 of 35 patients with globus hystericus, and in his entire series of 100 patients in anxiety or tension states, comments: "Chlormethazanone [Trancopal], by relieving the psychogenic symptoms, allows the patient to use his energies in a more productive manner in overcoming his basic problems."[5]

Relieves dysmenorrhea — Trancopal has also proved to be a useful medication in the treatment of patients with dysmenorrhea,[1,4,6] probably producing its effect ". . . by means of a combination of muscle relaxant and tranquilizing actions."[4]

Indications

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Ankle sprain, tennis elbow	Dysmenorrhea
Neck pain (torticollis)	Osteoarthritis	Premenstrual tension
Bursitis	Rheumatoid arthritis	Anxiety and tension states
Fibrositis	Disc syndrome	Asthma
Myositis	Postoperative muscle spasm	Angina pectoris
		Alcoholism

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms generally occurs promptly and lasts from four to six hours.

How Supplied: Trancopal Caplets® 100 mg. (peach colored, scored) and 200 mg. (green colored, scored), bottles of 100.

References: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 10:1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. 5. Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

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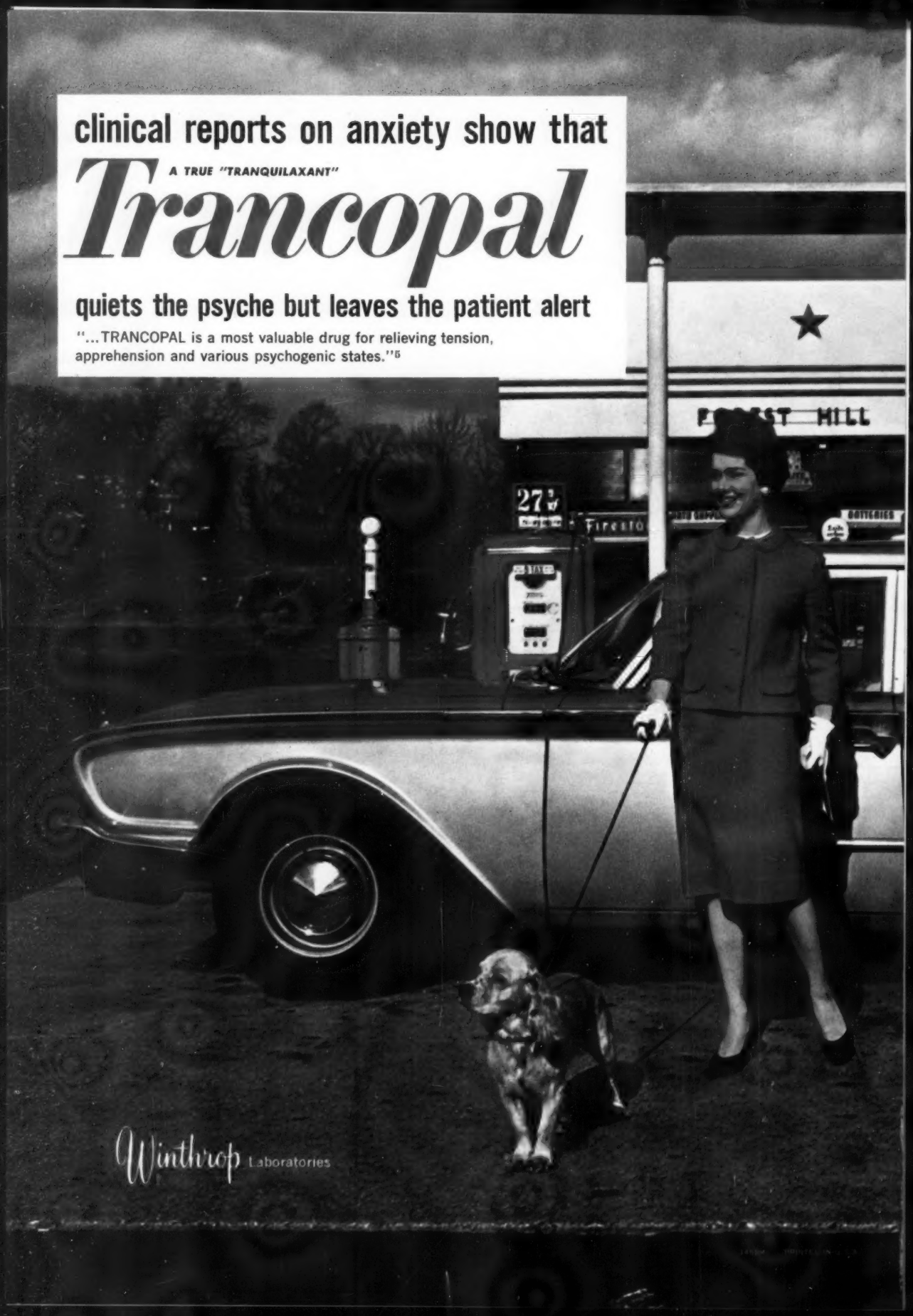
clinical reports on anxiety show that
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quiets the psyche but leaves the patient alert
"...TRANCOPAL is a most valuable drug for relieving tension, apprehension and various psychogenic states."[5]
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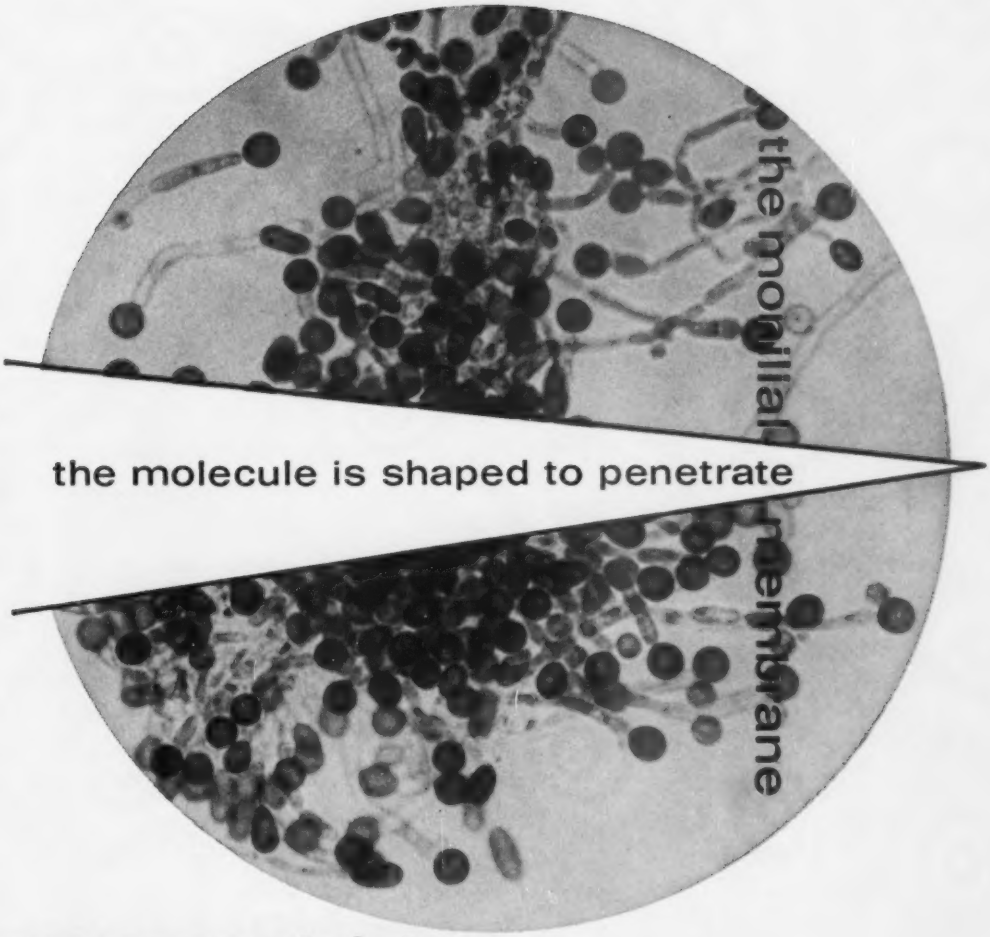

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*Lapan, B.: Am. J. Obst. & Gynec. 78:1320, 1959.

Ortho

President's Page

"ALAS BABYLON" IN YOUR COMMUNITY

Milton A. Darling

President
Michigan State Medical Society

Playhouse 90 presented a stirring production in early April illustrating the horrors of atomic warfare, adopted from the new book, "Alas Babylon." The intensely interesting facet of the TV show was the impact of such nuclear battle on individuals in the community after the bombs had been dropped.

The preservation of health and life in event of atomic attack was stressed at the national defense meeting held March 30 in Battle Creek, with the MSMS National Defense Committee as one of the sponsors.

The Conference stressed that no new organization in civil defense, especially in its medical and health phases, is planned. Instead, the speakers urged that the medical profession and health organizations should plan, within their own frameworks, to train people to cope with the new problems caused by a nuclear attack upon the United States. The treatment of radiation and of mass casualties are but two examples of new training requirements. The medical profession must determine what new techniques are necessary so that the nation's physicians, hospitals, and medical care organizations can meet the challenge of this age of great peril.

More organization at the local level was urged since in a nuclear emergency it may be necessary to survive many weeks without outside aid. This was the main theme of "Alas Babylon."

Our message, too, is a plea for more organization at the local level.

Every component society is urged to appoint an active civil defense committee which may contact the MSMS National Defense Committee for direction. Thus all local units will become an integral part of the over-all plan for protection of Michigan's citizens.

More appropriate today than ever before is the motto "BE PREPARED."

MSMS Workshop Proposes Ways To Solve Problems of The Aging

Ten possible solutions to challenges of the aging were proposed at a Michigan State Medical Society workshop April 3. Prominent leaders in medicine, health, education, government and civic service participated in the "MSMS Workshop on Services to the Aging."

"The positive workable ideas suggested at this workshop will be weighed carefully by the MSMS Council and by the MSMS Geriatrics Committee," assured H. J. Meier, M.D., chairman of The Council, in his workshop summary. "Many of the proposals today may well serve as blueprints for future MSMS actions," he observed.

The workshop program had two objectives; (1) to share new information and experience in the area of aging, and (2) to explore ways in which the medical profession can participate more actively in the Regional and Michigan Conferences on Aging.

"We must preserve the integrity and independence of every living person," he said. "The three basic health needs of all the people are medical/hospital care, facilities for convalescent care, and trained health personnel properly organized and motivated."

Lauds Senator Greene

Doctor Meier stated that much more information was needed about the aged and lauded Senator Perry Greene (R-Grand Rapids), who participated in the workshop, for his leadership in bringing about the newly created Michigan Commission on Aging.

In reference to the conference on health problems being held by Governor Williams to build a liberal program for the Democratic Party to follow nationally, Doctor Meier said, "I am sure that group will make a liberal contribution to the field, speaking in the vernacular of politics. I am equally sure that this Michigan State Medical Society Workshop will make a liberal contribution, of course, speaking in the vernacular of service."

Fredrick C. Swartz, M.D., Lansing, chairman of the American Medical Association Committee on Aging, presented the keynote address, "What Are the Facts About the Aging?" He told the group that doctors of medicine must participate in community and civic affairs.

Wants Facts Corrected

"Proponents of Forand-type legislation have distorted the facts and would have us believe that most of the aged are sick and infirm, and that their financial picture is drastically different from the rest of the population."

Dr. Swartz continued: "Regarding the incidence of illness, a recent survey shows that one in ten between the ages of sixty-five and seventy-four have some illness and one in five over seventy-five years of age have illness, which leaves 13 million oldsters in pretty good health. While this situation may not be ideal, it certainly is not the hopeless, gloomy picture presented by some.

"It has also been said that nearly two-thirds of the over-sixty-five have annual incomes of less than $1,000. If we accept this, it can similarly be shown that 60 million persons between the ages of fourteen and sixty-four have annual incomes of less than $1,000.

"From the standpoint of health and finances, the over-sixty-five have no difficulty or problem that is not shared by the under-sixty-five except forced retirement," he concluded.

Panel Studies 'Real' Health Needs

The "real" health needs of the aging were studied by four panelists at the workshop.

A. H. Hirschfeld, M.D., Detroit, a member of the MSMS Geriatrics Committee, said oldsters are being isolated and this creates a psychosis.

"Isolation and uselessness of the aged are the basic problems of the aged. The solution of other problems should be secondary.

"The gift of material substance is not a satisfying thing and it is certain that money itself will not make oldsters happy.

"The human requirements for happiness are satisfaction in a job well done and to love and be loved by those close to us," Doctor Hirschfeld explained.

Urges Scientific Study

Doctor Hirschfeld emphasized that scientific methods must be used to develop solutions to the total needs of the aged. This could best be done, he said, in cooperation with a medical school. Specifically, he suggested that model housing units for the aged be constructed close to a medical school so that faculty could study and evaluate the various ramifications of living past the age of sixty-five. Present liberalized mortgage laws would permit this construction using private capital.

"Such an experimental research plan for observation and experimentation could produce dramatic results," Doctor Hirschfeld concluded.

Daryl V. Minnis, East Lansing, Director, Ingham County Board of Social Welfare, as a member of the panel, discussed needs of the aged based upon the experience of the county social welfare agency. Mr. Minnis said there was a close tie between finances and health. Present Old Age Assistance cash benefits to needy over-sixty-five required supplementation by local county agencies. Not all counties in Michigan, he reported, supplemented the OAA $80 maximum monthly payments.

V. K. Volk, M.D., Saginaw, another member of the panel and Chairman of the Saginaw Regional Conference on Aging, reported that the size of the problem must be ascertained and that local needs must be identified. He suggested that research on aging needs should be a community project with county and state medical societies participating and providing leadership.

Pays Tribute to Council

Doctor Volk commended the MSMS Council for recommending in January that compulsory retirement be abolished, that work opportunities for the aged be provided, and that state and local governments be encouraged to share the purchase cost of voluntary health insurance for those over-sixty-five who need financial assistance.

J. K. Altland, M.D., Lansing, Michigan Department of Health, next on the panel, discussed how health departments could contribute to a team solution of the needs of the aged. He outlined the following activities as specific examples of aid: accumulation of health data; control of communicable disease; improvement of patient care in nursing homes through licensure; encouragement of rehabilitation procedures in nursing and convalescent homes; assistance in the development of chronic disease hospital units; further development of proprietary nursing homes; and extension of bedside nursing and visiting nurse programs.

Explains Aging Conferences

James E. Brophy, Detroit, Chairman of the Michigan Commission on Aging, spoke to the workshop about the forthcoming regional and state Conference on Aging which will make recommendation to the White House Conference on the Aging in January, 1961. He said seventy-two Michigan delegates will attend the White House meeting which will consider not only immediate problems of the aging but also means of preparing for retirement. This preparation should begin at age forty-five, he said.

It was inspiring to see the number of M.D.'s active in the field of aging, Mr. Brophy said, as he congratulated the MSMS for its activities.

Following the formal presentations, the Workshop participants formed discussion groups in order to explore every avenue of solution.

A. Hazen Price, M.D., Detroit, chairman of the MSMS Geriatrics Committee, told the workshop that most older persons are still useful citizens who want to maintain their independence and contribute to the community in which they live. Most are reasonably well, live in acceptable homes, and are capable of taking care of themselves.

"It is our feeling," he continued, "that the dignity of the individual must be maintained at all costs and every opportunity provided for him to pay for his needs and not be dependent upon state or federal aid except in cases of serious illness."

Asks Work for Aged

Speaking at the dinner which concluded the Workshop, Daniel Kruger, Professor of Economics, Michigan State University, said that local community action is the only way to solve the pressing unemployment problems facing those over-sixty-five.

Progress must be made with management and labor to correct both real and imaginary employment roadblocks, he warned. Professor Kruger pointed out that the two real roadblocks are the arbitrary retirement age of sixty-five and the changing nature of jobs.

In summarizing the Workshop, Doctor Meier said that the ideas formulated should be taken to the Regional Conferences on Aging by the workshop participants.

List Ten Proposals

He reviewed the programs receiving favorable comment at the workshop as follows:

1. Removal of compulsory retirement by industry and labor through voluntary and legislative action.
2. A program to provide work opportunities for the aged.
3. Encouragement of state and community governments to share the purchase cost of voluntary health insurance for those over-sixty-five who need financial assistance.
4. Participation by the medical profession in the preliminary meetings on local and state level prior to the 1961 White House Conference on Aging.
5. Increasing cash benefits to those receiving Old Age Assistance.
6. Exploring the possibility of including under OAA the "marginally indigent" person who is independent except for unusual trouble; and considering OAA as a possible mechanism for sharing of the premium cost of voluntary health insurance.
7. Possible establishment of a privately financed plan comparable to the Federal Deposit Insurance Corporation (which guarantees bank depositors against loss) which would guarantee health insurance premium payments, in whole or in part as need dictates, for those over-sixty-five who are unable to keep up such payments.
8. A pilot program for the construction of model housing units for the aged near a medical school so that scientific study could be given to the needs of the aged by faculty members. This could be done by private enterprise under present liberalized mortgage laws for this type of construction.
9. Educational program calling for pre-retirement planning beginning at age forty-five.
10. Emphasis on a preventive medicine program to include periodic health appraisals; gathering of health data, control of communicable disease, improving patient care and rehabilitation in nursing homes through licensure, and the developing of chronic disease hospital units.

Doctor Meier reported that the participants at this MSMS workshop were selected from leaders in the following organizations: Michigan Department of Health, Michigan Commission on Aging, Michigan Health Council, Michigan Gerontology Society, Michigan Joint Council to Improve the Health Care of the Aged, Michigan Society of Neurology and Psychiatry, Michigan Senate, Michigan State University, American Medical Association, and Michigan State Medical Society.

Cornell Asks MSMS Aid Again

The Cornell university automotive crash injury research program, which started in Michigan in 1957 and ran for two years, will resume for another two years.

The same organizations which participated in the original study, the Michigan state police, the state department of health and physicians with the endorsement and cooperation of the Michigan State Medical Society and Michigan Hospital Association, will continue to cooperate.

Eighteen other states also are taking part in the study.

The new program in Michigan, which will extend from May 1, 1960 to April 30, 1962, will be similar to the previous one except that the volume of reports will be considerably less, with reports being required only on passenger cars involved in accidents which result in death or injury to an occupant.

Purpose of the studies is to determine causes for death and injury in accidents with an end toward finding means of building greater safety features in motor vehicles.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

June 17-18	Upper Peninsula Medical Society	Escanaba
July 28-29	Coller-Penberthy Clinic	Traverse City
September 25-30	Michigan State Medical Society Annual Session	Grand Rapids

HIGHLIGHTS of MSMS Council Meeting

Meeting of March 7, 1960

Twenty-one members of The Council were present at this seven-hour meeting at which 83 items were considered. Chief in importance were:

- Forand-type legislation was thoroughly discussed; a report on MSMS activities in this field was presented to and received by The Council. A talk was recently prepared by MSMS and delivered to date before 9 county medical societies, mainly by the Councilor of the District.
- Correspondence from the two medical school deans in Michigan recommending that the MSMS Liaison Committee meet with the administration of both schools to consider matters of mutual interest was referred to the Chairman of the Committee, B. M. Harris, M.D., Ypsilanti.
- Meeting with Michigan State University re proposed third medical school: Secretary Wiley reported on this meeting to which MSMS sent an observer. MSMS is interested in further exploration concerning the possibility of a third medical school in Michigan.
- Speaker J. J. Lightbody, M.D., Detroit, reported that all eight committees of the House of Delegates were appointed and most have held one or more meetings.
- Legal Counsel Lester P. Dodd presented opinion re patient refusing psychiatric treatment: a physician cannot bring in a consulting physician or refer a patient for psychiatric treatment without the consent of the patient. Mr. Dodd also reported on the February 3 meeting with the Genesee County Medical Society Board of Directors to discuss a Flint hospital problem. He also reported preliminarily on Internal Revenue Service action re Kintner-type associations —Internal Revenue Service plans to hold hearings on its proposed rules before they are made final.
- Public Relations Counsel H. W. Brenneman reported on legislation, both national and state; progress on the new MSMS publication "Medical Economic Currents"; disposition of 1957 opinion survey questionnaires; progress report on Michigan Health Council and Michigan Association of the Professions.
- Committee reports considered were:
  1. Mental Health Committee, January 25.
  2. Residents-Interns-Senior Medical Students Conference, Program Committee, January 27.
  3. Public Relations Committee, January 21.
  4. Committee on Rural Medical Service, February 3.
  5. Advisory Committee to MSMAS, February 7.
  6. Wayne County Councilor District Medical Care Insurance Committee, February 11.
  7. Venereal Disease Control Committee, February 18.
  8. Big Look Committee, March 7.
- Progress report on Michigan Medical Service. President G. Thomas McKean, M.D., Detroit, reported on the present financial condition of MMS, and that MMS was sending out its Annual Report to all Michigan doctors of medicine.
- Michigan Cancer Coordinating Committee. The question whether the Michigan Cancer Foundation should be approved as a member-organization of MCCC gained the affirmative vote of The Council. The Council recommended to the 1960 MSMS House of Delegates that the MSMS Cancer Control Committee be reconstituted as it is an advisory committee whose guidance is necessary.
- Appointments. 1. Representatives to Upper Peninsula Medical Society annual meeting, Escanaba, June 17-18: K. H. Johnson, M.D., Lansing, H. J. Meier, M.D., Coldwater, T. P. Wickliffe, M.D., Calumet, H. F. Falls, M.D., Ann Arbor, and Warren F. Tryloff, Lansing.

  2. To AMA meeting, June 13-14: Milton A. Darling, M.D., Detroit, J. J. Lightbody, M.D., Detroit, D. Bruce Wiley, M.D., Utica, Wm. J. Burns, and H. W. Brenneman, of Lansing.

  3. MSMS representatives to Michigan Cancer Coordinating Committee: E. I. Carr, M.D., Lansing, Wm. A. Hyland, M.D., Grand Rapids, J. W. Hubly, M.D., Battle Creek, H. M. Pollard, M.D., Ann Arbor, and Alternate H. J. Vandenberg, Jr., M.D., Detroit.

  4. MSMS representatives to annual Michigan Day; Washington, D. C., May 2-3: Milton A. Darling, M.D., K. H. Johnson, M.D., D. Bruce Wiley, M.D., H. J. Meier, M.D., and H. W. Brenneman.

  5. New Ad Hoc Committee Concerning Practice of Chiropody: L. A. Drolett, M.D., Lansing, Chairman; Wm. H. Blodgett, M.D., Detroit; B. M. Harris, M.D., Ypsilanti; R. J. Mason, M.D., Birmingham; and G. Thomas McKean, M.D., Detroit.

  6. Chairman of Eighth Councilor District MCIC: C. W. Cory, M.D., Saginaw.

  7. Representatives to AMA National Congress on Prepaid Health Insurance, Chicago, May 13-14: A. Jackson Day, M.D., Detroit, J. W. Rice, M.D., Jackson, D. N. Sweeny, Jr., M.D., Detroit.

  8. MSMS Representative to Regional Meeting on Veterans' Affairs, Indianapolis, in September: Wm. Bromme, M.D., Detroit.

(Continued on Page 720)

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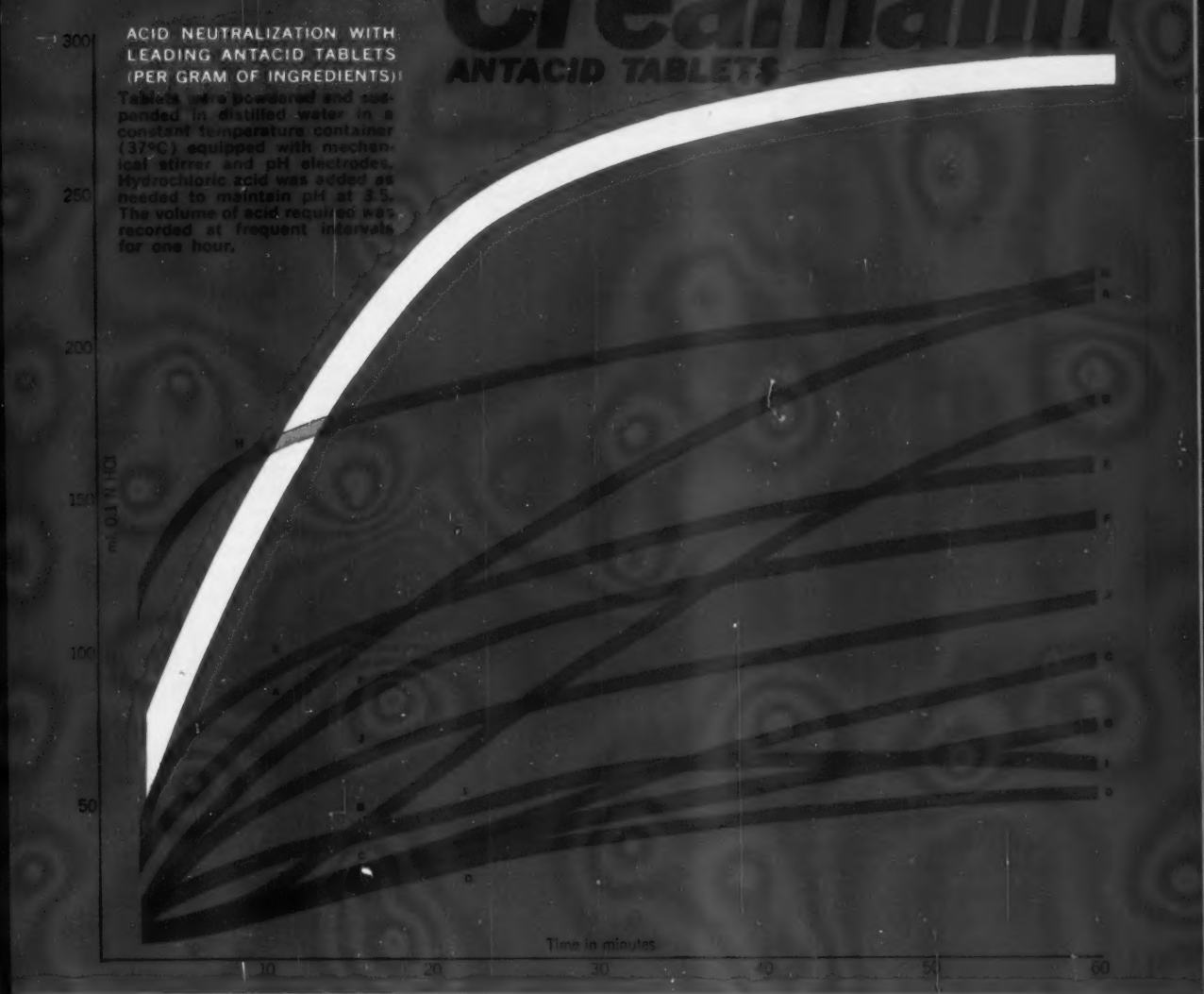

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Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

How Supplied: Bottles of 50, 100, 200 and 1000.

1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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MSMS Council Meeting

(Continued from Page 718)

9. MSMS representative at U-M Doctors' Day, Ann Arbor, May 14: President Milton A. Darling, M.D.

10. MSMS representative to White House Conference on Children and Youth, Washington, D. C., March 28: R. M. Heavenrich, M.D., Saginaw.

11. Nominees to Board of Trustees of Michigan Hospital Service: W. W. Babcock, M.D., Detroit; Wm. M. LeFevre, M.D., Muskegon; and D. R. Smith, M.D., Iron Mountain.

12. MSMS Representatives to AMA preliminary program on 1961 White House Conference on Aging: A. Hazen Price, M.D., Detroit, A. E. Heustis, M.D., Lansing, and Executive Director Wm. J. Burns.

- Financial report and bills payable were presented, given study, and approved by The Council.

Interim Report of House of Delegates Committee to Study MSMS Publications

The Committee met in Detroit on January 28, 1960, and in accordance with the House of Delegates action reviewed and made recommendation on the following matters:

1. *Editorial Policy of* THE JOURNAL *of MSMS.* The role of the Publication Committee of The Council was reported and Editor Haughey's present policy of distributing advance copies of his editorials to MSMS officers and members of the Publication Committee for approval or correction prior to publication was reviewed. Following full discussion, the Committee voiced its approval and recommended continuation of the editorial procedure to date of Editor Haughey, particularly his system of sending out editorials in advance for recommendations.

2. *Election of the Editor.* The present procedure whereby the Editor is elected annually by the MSMS Council was reviewed and pointed out as an example of government by representation. The Committee members felt that the Editor should not be at variance with the current administration and therefore respectfully recommended that The Council only nominate one or more persons to serve as Editor for a one-year term and that these nominations be submitted to the House of Delegates for election at its Annual Session.

3. *New Format and Changes in* THE JOURNAL. The Committee reviewed the many recent changes made to improve readability and noted that JMSMS had been rated highly at the recent Conference of State Medical Society Journal Editors. The Committee noted with approbation the high quality of THE JOURNAL under the direction of Editor Haughey.

4. *Advertising Policies and Publication Problems.* The Committee recommended that all scientific articles be printed on consecutive pages so as to improve readership, instead of continuing lengthy articles as is now done. It also suggested that "Letters to the Editor" be encouraged.

5. *Review of Secretary's Letter and Legislative Report.* Following review, the Committee approved of these news publications and recommended their continuation.

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E. E. MARTMER, M.D.
C. ALLEN PAYNE, M.D.
D. I. SUGAR, M.D.
F. L. TROOST, M.D.
O. J. JOHNSON, M.D., *Chairman*

NOTE: The Council, at its January 30 Annual Meeting, adopted the following: "That the Publication Committee of The Council assume responsibility as the Editorial Board for THE JOURNAL; that all editorials shall be submitted to the members of that Committee; that it is the intent of this action that the Publication Committee acting as the Editorial Board assume, with the Editor, the responsibility for all editorials printed in THE JOURNAL and shall act in a consultative capacity for other items in THE JOURNAL."

MSMS Sponsors Workshop On Disaster Medical Care

More than 150 physicians, key medical and hospital personnel from Michigan attended a Disaster Medical Care workshop presented in Battle Creek on March 30 by the Michigan State Medical Society.

Frank O. Starr, Director, Region 4, Office of Civil and Defense Mobilization, told the group they must utilize their present medical organizations to plan the action that would be necessary to meet major disasters.

Others on the program were William Powell, Deputy Director of the Michigan State Office of Civil Defense; Douglas H. Fryer, M.D., Director, Local Health Administration, Michigan Department of Health; C. P. Anderson, M.D., G. L. Otis, M.D., Merle E. Wehner, M.D., and Ronald Yaw, members of the Committee on National Defense of the Michigan State Medical Society, and Paul Lindquist, M.D., Deputy for Operations, Health Services, OCDM.

The afternoon sessions were devoted to workshops concerned with how doctors and hospitals can meet the needs of disaster medical care. David Walchembach, Chairman, Disaster Planning Committee of the Michigan Hospital Association presided over the meeting.

The conference was greeted by Milton A. Darling, M.D., President, Michigan State Medical Society and A. Kent Schafer, President Michigan Hospital Association.

Below — The final MCI closed-circuit colored telecast considered "Clinical Aspects of Aging." Shown on camera are Fredrick C. Swartz, M.D., left, Lansing, and James E. Birren, Ph.D., Bethesda, Md.

Above—One of the many clinical movies shown at each MCI by the American Cyanamid Company is checked by O. M. Chickering, Detroit, regional manager.

Photos Help to Tell MCI Story

A familiar scene at the annual MCI is the speaker's platform, where C. S. Stevenson, M.D., Detroit, introduces Eugene N. Beesley, seated, president of Eli Lilly and Company, Indianapolis.

MSMS President and Mrs. Milton A. Darling, at right, are introduced by William Bromme, M.D., second from left, Detroit, to R. F. Goodspeed, at left, Wayne State University senior medical student, during the annual Conference for Residents, Interns and Senior Medical Students.

MSMS President-Elect and Mrs. Kenneth H. Johnson, at right, meet Robert Fisher, at left, University of Michigan senior medical student, during the Conference for Residents, Interns and Senior Medical Students. Making the introduction are Dr. and Mrs. Archie A. Claytor, of Saginaw. Doctor Claytor is Michigan's Foremost Family Physician.

Cancer Quackery folders catch the interest of the Cancer Control panel—left to right, S. M. Sessoms, M.D., Bethesda, Md., M. J. Brennan, M.D., Detroit, R. W. Talley, M.D., Detroit, E. P. Vollmer, Ph.D., Bethesda, Md., and Harry M. Nelson, M.D., Detroit, who introduced the panel.

1960 MCI Shares "Tomorrow's" Knowledge Today

The participants at the 1960 Michigan Clinical Institute at Detroit benefited with "Tomorrow's Medicine Today" as the theme promised.

There were new methods of treatment demonstrated, new fields of research explained, new areas of treatment discussed.

There were new technical exhibits, new products, new displays.

And there was a new enthusiasm at the 1960 MCI, the fourteenth annual refresher course.

Total registrations reached 2,671. This included 1,260 doctors of medicine, 157 medical assistants and 272 students. And there also were 325 operating room nurses and 33 other nurses. The total attendance also included 208 other guests including wives, and 416 exhibitors.

* * *

THE GENERAL CHAIRMAN was R. J. Hubbell, M.D., MSMS Past President, of Suttons Bay.

The official program started Tuesday afternoon, March 8, with a simultaneous opening of the exhibits. Addresses of welcome were given by Milton A. Darling, M.D., President of the Michigan State Medical Society and Milton R. Weed, M.D., President of the Wayne County Medical Society. The Michigan Chapter of the American Academy of Pediatrics had met that morning at the Children's Hospital auditorium with a full session.

THE FIRST SESSION of the Michigan Clinical Institute was devoted to Cancer Control with a panel sponsored by the Michigan Cancer Coordinating Committee on "Chemotherapy of Cancer." This was a most inspiring discussion outlining advances made in many lines of research in attempting to control cancer. In the late afternoon there was another symposium on "Steroids."

On the second day—"General Practice Day—Surgery"—there were two interesting papers presented. The color television program as in the past several years was a closed circuit devoted to "Surgery of the Skin and Subcutaneous Tissues," a panel on "Varicose Ulcers," and a panel on "Hospital Care of a Surgical Wound." These TV shows were remarkably well attended, the Grand Ballroom being essentially full much of the time.

* * *

THE SECOND DAY WAS devoted to Trauma. The papers covered "Treatment of Traumatic Shock," "Fractures In Children," "The Hazards of Iatrogenic Pneumothorax in Certain Diagnostic and Therapeutic Procedures," "The Challenge of Facial Lacerations," "Trauma and Whole Body Irradiation." The evening of the second day was devoted to "Problems of Juvenile Delinquency." The chairman was John M. Dorsey, M.D., of Detroit, with six participants. This was opened to the ladies.

THE THIRD DAY devoted to Heart and Rheumatic Fever had a panel on "Hypertension." Then followed a closed channel television program again from Harper Hospital, produced by the kindness of Smith, Kline and French Laboratories of Philadelphia. There was a demonstration and discussion of "The Physical Signs of Congestive Heart Failure," followed by "The Diagnosis of Carotid Arterial Occlusion" and "Cardiac Arrest in the Operating Room" with instructions and demonstrations on opening the chest wall and massaging the heart back into action. The demonstrator had saved many patients by this procedure. He said, don't wait, whatever doctor is present when heart failure happens—get into the chest with two long incisions at the rib margin and immediately put the hand in and start massaging, then have somebody else start oxygen, fresh blood to be pumped farther into the system and keep compressing the heart until you have about 80 units blood pressure. By that time relief should be around and take turns. Sometimes this service has to be continued for two or three hours. This was a most useful and encouraging demonstration and was of particular interest to the Battle Creek visitors because the President of the Calhoun County Medical Society had himself just gone through that process—heart failure from a coronary—chest opened —heart massaged—and general care. The next TV program was "Glaucoma with Instruction in Tonometry," "Common Ocular Fundus Findings" and "Common External Eye Diseases."

In the afternoon—Internal Medicine, "A New Look At Food Poisoning," "Evaluation of Drugs," "Blood Component Therapy," "Aerospace Medicine." The last item that day, sponsored by the Michigan Foundation for Medical and Health Education was a clinical movie of "Patient With Multiple Personality" by Corbett H. Thigpen, M.D., of Augusta, Georgia, from the Department of Psychiatry of the Medical College of Georgia.

THE LAST DAY was devoted to Obstetrics and Gynecology on "Today's Challenges for the Health Team" and "Prolonged Labor." A closed television was devoted to "Early Detection of Cervical Carcinoma: Cytologic Techniques"; a panel on "Prolapse Uteri" and a panel on "Clinical Aspects of Aging."

OCCURRING AT THE SAME TIME as this Clinical Conference was a Conference for Residents, Interns and Senior Medical Students of Michigan, and ending with a reception honoring President and Mrs. Milton A. Darling of Detroit.

Also on Wednesday at the Fort Shelby Hotel there was a meeting of the Michigan State Medical Assistants Society.

On March 10 and 11 the Operating Room Nurses Institute met.

There was a complete program during the whole period of color motion pictures presented by the American Cyanamid Company. Technical exhibits were up to standards set many years ago with some new additions, new methods of display and new enthusiasm.

MD's Address Clubs During Clinical Institute

Detroit area service clubs again hosted physician-speakers for their luncheon meetings during the Michigan Clinical Institute. Business and professional people and civic leaders have demonstrated their appreciation for these M.D.-speaker-programs by inviting them back each year, and by their complimentary letters following the talks.

The MCI Service Club Speakers for 1960 were:

Warrendale Kiwanis Club, Charles W. Sellers, M.D., Detroit.

Exchange Club of Detroit, Ira M. Altshuler, M.D., Detroit.

Kiwanis Club of Grosse Pointe, Chauncey J. Hipps, M.D., Detroit.

Art Center Kiwanis, Glenn E. Millard, M.D., Detroit.

Mt. Clemens Kiwanis, Kathryn McMorrow, M.D., East Detroit.

Kiwanis Club of Central Detroit, Douglas A. Sargent, M.D., Detroit.

Kiwanis No. 1, Alexander H. Hirschfeld, M.D., Detroit.

Detroit Denby Kiwanis, Sidney E. Chapin, M.D., Dearborn.

Civitan Club, Chauncey J. Hipps, M.D., Detroit.

Louis Stone Chapter, B'nai B'rith, Ira M. Altshuler, M.D., Detroit.

Royal Oak Exchange Club, Neal Brady, M.D., Royal Oak.

West Pontiac Kiwanis, Robert Pool, Jr., M.D., Pontiac.

Excalibur Club, C. Howard Ross, M. D., Ann Arbor.

U & I Club, Jack Rom, M.D., Detroit.

Jackson School PTA in Livonia, Harvey Stein, M.D., Livonia.

Downriver Branch of Auxiliary to WCMS, Richard Philleo, MSMS, Lansing.

University of Detroit, P.R. Class, H. W. Brenneman, MSMS, Lansing.

The MSMS Public Relations Committee is indebted to the physicians taking time from their busy practices to talk with these service club groups.

What They Said About MCI

After every Michigan Clinical Institute, the State Society receives many letters from guest essayists, special guests, exhibitors and others voicing their comments. The following are samples from some letters:

"I would like for you to know what a wonderful time I had in Detroit and how cordially I felt that I was received. I really had no conception of the honor that you were offering me when you asked me to be Foundation Lecturer for the Michigan Clinical Institute. You mentioned that there would be a certificate but I didn't dream that it was such a signal honor. I really feel quite humbled by the scroll."—*Corbett H. Thigpen, M.D.*, Augusta, Ga., Guest Essayist.

* * *

"Back in Chicago after a very pleasant visit to Detroit and participation in the Michigan Clinical Institute.

"In spite of the early hour of 9:00 this morning, your group had a very gratifying turnout. It is a tremendous job which you fellows do in arranging programs for this annual affair."—*Walter G. Maddock, M.D.*, Chicago, Guest Essayist.

* * *

"Participating in the program of the Michigan Clinical Institute on March 8 was both an honor and a pleasure. I hope the material presented and the topics covered met the needs of the program."—*Stuart M. Sessoms, M.D.*, Bethesda, Md., Guest Essayist.

* * *

"I enjoyed my trip to Detroit very much and only hope that my presentation to your group was the type of presentation that they wished to hear. I heard some comments in the audience that they were glad that I had stressed the things that I had in fractures in children, so perhaps it was interesting to at least some of them."—*Claude N. Lambert, M.D.*, Chicago, Guest Essayist.

* * *

"Thank you for the opportunity of meeting with the members of your Society in Detroit."—*Merle M. Musselman, M.D.*, Omaha, Guest Essayist.

* * *

"I want to tell you how much I enjoyed participating in the Fourteenth Annual Michigan Clinical Institute and hope that our discussions on aging were of some value."—*N. W. Shock, M.D.*, Bethesda, Md., Guest Essayist.

* * *

"My heartiest congratulations go out to Doctor Hubbell for his excellent work as chairman of the Committee on Arrangements for the Michigan Clinical Institute. Every one of us physicians is grateful to Dr. Hubbell."—*John M. Dorsey, M. D.*, Detroit, Guest Essayist.

See Page 762 for late "State Society" news about the program for the Upper Peninsula Medical Society meeting, June 17-18.

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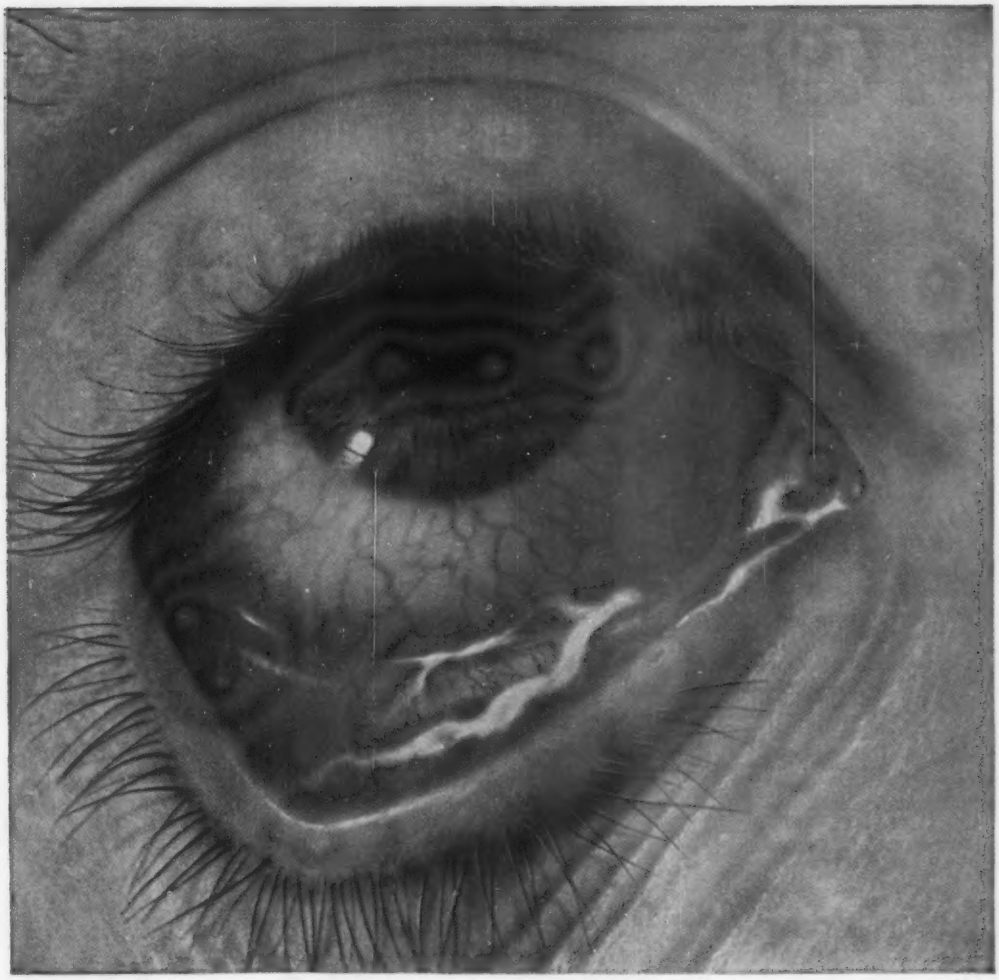

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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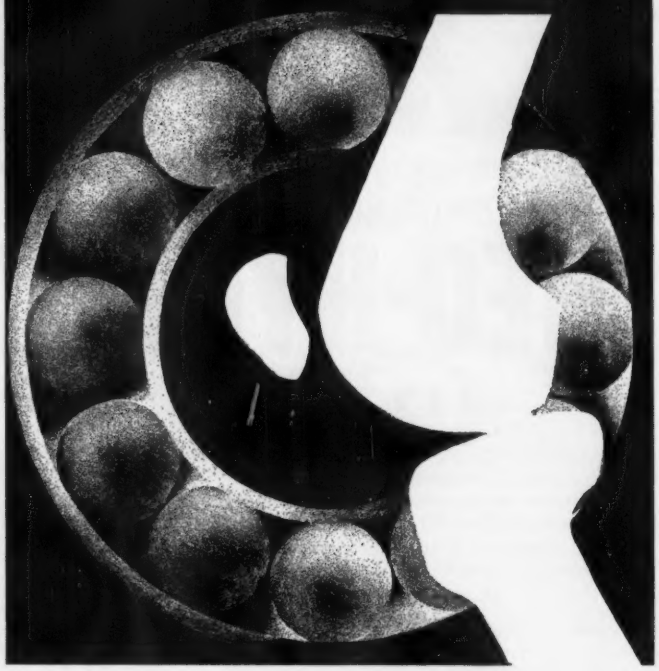

Geigy

BU 7-60

This Is the Year

Ever since August of 1957, when Congressman Aime Forand (D-Rd. Island) first proposed to add health benefits to the Social Security law, political seers have predicted that the 1960 presidential elections would make this year the make-it-or-break-it year for his Forand Bill. These prophesies have been borne out.

All of the presidential aspirants have indicated a keen desire to "do something for the elderly", and both political parties are busy drafting watered-down Forand Bills and alternative proposals in the hope of finding something they can sell to the American public . . . for votes.

Organized labor has broken all existing records of political pressure in its campaign for Congressional approval of the bill before adjournment this year.

Medicine's decision to withhold support from ANY legislative nostrum in the present absence of an accurate nationwide analysis of the true needs of all the elderly may seem overly cautious to its more spirited critics, but it is a decision borne of long experience in meeting the health needs of the public.

The medical profession and its many allies are determined that 1960 will be known as the year that America stopped the march of socialism (at least in health care) once and for all; and although victory is not predictable at this writing, Michigan's physicians have made notable contributions to the battle, some of which are listed below as an indication of their awareness to the gravity of the situation:

- Special delegations of MSMS were sent to two nationwide A.M.A. briefings on Medicine's 1960 campaign, one in St. Louis in October last year, and one in Chicago last January.
- The opening day's session (January 30) of the MSMS Annual County Secretaries-Public Relations Seminar, to which all county medical society officers, editors, and public relations committee chairmen were invited, was devoted exclusively to discussions by top experts on the problems of the aging and the Forand Bill.
- On April 3, in marked contrast to a political conclave sponsored by Michigan's G. Mennen Williams and devoted to developing a national Democratic platform on health matters, the Michigan State Medical Society hosted a special "Workshop on Services to the Aging," to which eight outstanding authorities on the problems of our senior citizens were invited to meet with twenty-seven key Michigan medical personnel.
- Some of the ten suggestions offered by the Workshop participants for improving the lot of the aging were: (1) cessation of compulsory retirement policies by industry and labor; (2) sharing by the state and community of the cost of voluntary health insurance for those persons in need of assistance; (3) increasing Old Age Assistance programs and providing special financial aid to the "marginally indigent"; (4) inaugura-

tion of pilot studies of new concepts in housing facilities for the aged; (5) encouragement of pre-retirement planning programs in industry; and (6) stimulation of greater interest in preventive medicine programs by the individual throughout his lifetime.

- Members of a specially organized speaker's bureau, county medical society officers, and MSMS Councilors presented talks on the Forand proposal to numerous medical, auxiliary, and lay audiences in every part of the state.
- Thousands of pieces of especially prepared literature, bulletins, pamphlets, and editorial reprints have been distributed to member physicians and the public.

The Keogh Bill

The year 1960 also may be signfiicant to self-employed persons in that the chance for passage by Congress of the so-called Keogh Bill appears the best ever. Variously known as the "Jenkins-Keogh", "Simpson-Keogh", and "Smathers-Keogh" Bills, HR 10 would grant tax equity to farmers, professional persons, and the other self-employed by permitting such taxpayers to deduct (for income tax purposes) contributions up to $2500 annually made to individual retirement programs, thus ending the present discrimination between employees who may join company pension plans and self-employed persons who may not.

The Treasury Department's past opposition to the bill has softened, and it is believed some compromise measure will emerge from this Session.

County Society News Round-Up

GENESEE—The second annual Conference on the Health of High School Athletes will be conducted by the Genesee County Medical Society May 25 at the Southwestern High School. The program will begin at 9 a.m., continue through the luncheon and adjourn in the mid-afternoon. The event is open to all coaches, trainers, administrators, physical educators and physicians.

JACKSON—The Jackson Citizen-Patriot, at the request of the *Jackson County Medical Society*, published a half-page chart on poison prevention. The article suggested that the chart be clipped and attached to the medicine cabinet door. The headline read, "Danger Lurks—Unless You Follow These Medical Society Poison Prevention Directions."

KALAMAZOO—The first joint meeting of the clergy and physicians was held at the regular March meeting of the *Kalamazoo County Academy of Medicine*. Guest speaker at the event sponsored by the Academy to promote greater understanding of the common role each group plays in working with the sick was Edgar Draper, M.D., of the University of Chicago.

WAYNE—Improved and enlarged emergency service sponsored by the *Wayne County Medical Society* was publicly announced by president M. R. Weed, M.D., and F. B. Levagood, M.D., chairman of the Medical Service Bureau Committee. Newspaper reports told how the Society had divided the city according to postal zones and calls are relayed to the nearest available physician on a rotation basis. The Bureau also makes referrals and answers calls for doctors whose phones are not manned.

GRATIOT-ISABELLA-CLARE—A panel of three doctors of medicine addressed the Mount Pleasant Rotary Club on the subjects of public health, glaucoma and coronary disease. Participants were E. J. Brenner, M.D., S. L. Chamichian, M.D., and John M. Wood, M.D.

HOUGHTON - BARAGA - KEWEENAW — The third Annual Copper Country Career Day for the ninth graders, was held April 23 in Hancock. Sponsors were the *Houghton-Baraga-Keweenaw County Medical Society*, Copper District Dental Society, and the Bar Association, assisted by the Woman's Auxiliaries. H. J. Winkler, M.D., is president of the Houghton-Baraga-Keweenaw County Medical Society.

Initiated as a service to the youth of the area high schools in 1958, Career Day has become a significant event on the school calendar. Supplementing existing guidance programs, Career Day offers ninth grade students the opportunity to explore possibilities in three career fields of their choice, through conferences with experienced consultants. Ninth graders were selected as a pilot group since they still have time to alter their courses to meet college requirements.

in infectious disease[17,22,30,36]
in arthritis[16,19,20,29]
in hepatic disease[2,3,4,9,38]
in malabsorption syndrome[1,2,6,37]
in degenerative disease[6,7,13,20,42]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,35]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[31,32,33,34]
in alcoholism[9,11,33,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[12,19,20]
in pancreatitis[15]
in female climacteric[12,34]

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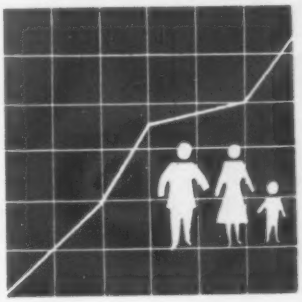
(Excerpts from the address given by Erwin D. Canham, President, Chamber of Commerce of the United States, at the organizational meeting of the new Michigan State Chamber of Commerce in Lansing.)



"You have brought into being a new voluntary organization of particular and specialized importance.

"Now that you have a State Chamber of Commerce, the business and professional men of Michigan—both urban and rural—can approach their statewide problems in a new way.

"You are now, for example, in an advantageous position to analyze statewide problems and to develop a sound program of research. Nothing could be more important. It is a question of concentrated fire—which is now possible—as compared to scattered fire.

* * *

"AND—IN ORGANIZING as you did—you emphasized the significance of the state as a political and economic unit.

"In recent years, we seem to have slipped away from the concept of the state's very special significance. We seem to have forgotten that the states are in fact the fathers of the national government. We have allowed the child to get somewhat out of hand.

"One hundred eighty years ago, the states gave the federal government a limited authority. It was a delegated authority. The federal government had no inherent powers.

"The state is still our most important single unit of government. All undelegated, undefined and unused powers reside in the states. Our counties, cities and school districts are all creations of the states. The state administers the great bulk of our civil and common laws. Indeed, approximately 90 per cent of legislation affecting our personal lives is state-administered.

"Michigan has an especially versatile economy.

"Within your boundaries is the automobile capital of the world. Your larger urban centers contain other manufacturing and processing industries—large and small—in great number. But Michigan also produces ore and timber. It is an important agricultural state—with a highly productive fruit belt. The recreation industry—the tourist business—is also important to your state's economy.

"You in Michigan have a very personal interest in a better national business climate.

* * *

"YOUR EIGHT MILLION citizens bear approximately 5 per cent of our national budget. In this last year alone, our national government is taking approximately three and eight-tenths billions of dollars out of Michigan. You are sending to Washington half again as much as the amount you spend to operate your own state government. (State general expenditures for 1958, $2.8 billion.)

"It is true, of course, that some of the money you send to Washington finds its way back to Michigan in the form of federal funds expended for some of your products in the interests of national

defense—and for services which are properly the function of the national government—such as navigation services—weather stations—and for interstate highways.

"But I am not thinking of federal expenditures for the responsibilities which have been logically assigned to the national government. I am thinking of so-called 'federal-aid'—which is a misnomer, although the phrase has entrenched itself in the American language, and I am afraid we are stuck with it.

"That figure of speech implies that a state or a community actually gets a handout from the federal treasury. The exact opposite is true—and certainly in the case of Michigan. In the case of Michigan, every dollar you receive in the form of a federal grant costs you about $1.44.

* * *

"THIS IS A MICHIGAN problem to some extent, but it is mostly a national problem. The pork barrel is too popular. The best way to resolve the problem—to cope with it—to confront it—is through voluntary action.

"Voluntary action is our nation's great tool in showing the rest of the world the way to solve problems without throwing ourselves slavishly into the arms of government.

"We all know that the future of this country is in the hands of educated—informed—men and women who are not indifferent—and who are willing to work for the general good.

"In the future of this country, nothing is more important than the state of mind of the American people. Upon that state of mind depends whether or not we shall carry out the principles so eloquently lived by the men who risked their lives, their fortunes and their sacred honors to bring about our independence.

* * *

"WE NEED TO RECAPTURE the zeal, dedication and practical exemplification which have been ours in our great historic moments.

"Whatever we do today, is of world wide significance. No one of us can afford the opium of inertia or self-indulgence. We live today in a new relationship with nature. The greatest fact of our century, surely is not atomic fission, nor great wars, nor power rivalries between two portentous systems, not even the awakenings of peoples. It is the growth of knowledge—the fantastic pyramiding of knowledge.

"But with our knowledge must come vision—insight—penetration—the still small voice of inspiration. Let us pray for wisdom."

Blue Shield Total Rises; 24 Per Cent of U. S. Covered

More than 44,700,000 persons were enrolled in the various Blue Shield Plans located in North America as of December 31, 1959, the National Association of Blue Shield Plans reported March 4, 1960 in Chicago.

Total membership reached 44,792,923, which represents an enrollment of 24 per cent of the total United States population and nearly 15 per cent of the total Canadian population.

"The net gain in membership for 1959 amounted to 2,217,667, which is significant improvement over the 1,096,203 gain for the year 1958," the national association also indicated in its year-end report.

Several Blue Shield Plans recorded impressive enrollment gains during the past year. The Blue Shield Plan serving the Province of Ontario registered a net gain of 379,092 members, the Pennsylvania Blue Shield Plan added 247,435 members and the Chicago Plan 166,691 members. Two Blue Shield Plans had enrolled more than 60 per cent of the population in the areas they serve at the end of 1959. The District of Columbia Plan has more than 68 per cent, while the Delaware Plan has enrolled almost 61 per cent.

"The acceptance of Blue Shield as a means of helping to pay medical-surgical bills is reflected in the growth of these Plans in the past decade. Blue Shield has grown from a membership of more than 16,500,000 in 1950 to its present figure only through the offering of a program that has continued to meet the demands and needs of the American public," the report concluded.

Defends Use of Brand Names On Prescriptions at Testimony

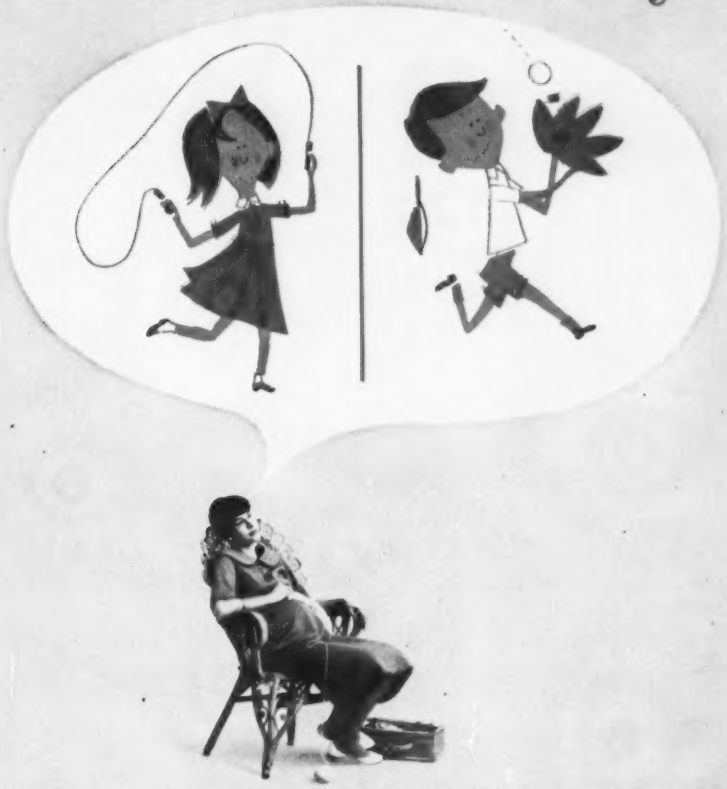
The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Austin Smith, M.D., President of the Pharmaceutical Manufacturers Association, testified at a Subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side

(Continued on Page 738)

51 to 49...it's a boy!



94 to 6 BONADOXIN® stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male.[1] But when she mentions morning sickness, your course is clear: BONADOXIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%.[2] More than 60 million of these tiny tablets have been taken. The formula: 25 mg. Meclizine HCl (for antinauseant action) and 50 mg. Pyridoxine HCl (for metabolic replacement). Just one tablet the night before is usually enough.

BONADOXIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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Science for the World's Well-Being

Defends Use of Brand Names

(Continued from Page 736)

effects that might have importance for a particular patient," Dr. Smith said.

R. B. Robins, M.D., of Camden, Arkansas, who accompanied Dr. Smith at the hearing, submitted a similar statement. He said he used trade names because: "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Dr. Robins appeared before the Subcommittee as a private practicing physician and not in his capacity as a member of the AMA Board of Trustees.

Despite this testimony, Sen. Estes Kefauver, (D. Tenn.), the Chairman of the Subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

Death Rates About Same Now In Poor or Wealthy States

"All states have increased their spending between 1930 and 1957 for medical care—a key factor in the 37 per cent drop in the national death rate since 1930."

So states George Bugbee, president of the Health Information Foundation, as the Foundation reports research in mortality rates and overall health levels.

But the effect of increased spending for health is reflected most dramatically in the low-income states, where conditions were worse to begin with. "As the poorer states have improved financially," said Mr. Bugbee, "they have greatly stepped up their spending for health services and facilities." Higher incomes in the poor states also have undoubtedly improved educational nutritional levels to help lengthen the life span."

In 1930, H.I.F. found death rates were 13 per cent higher in the 10 states with lowest per capita incomes than in the 10 wealthiest states. By 1947 the gap had virtually closed—death rates in the poorer states were only 1 per cent higher.

Despite the general similarity in mortality rates in low-and-high-income states, there are still significant differences between the groups. The Foundation reported, for example, that the low-income states have relatively poor mortality records during infancy, childhood, and even the adult ages. At ages 65 and over, however, the mortality record is actually better in the low-income states.

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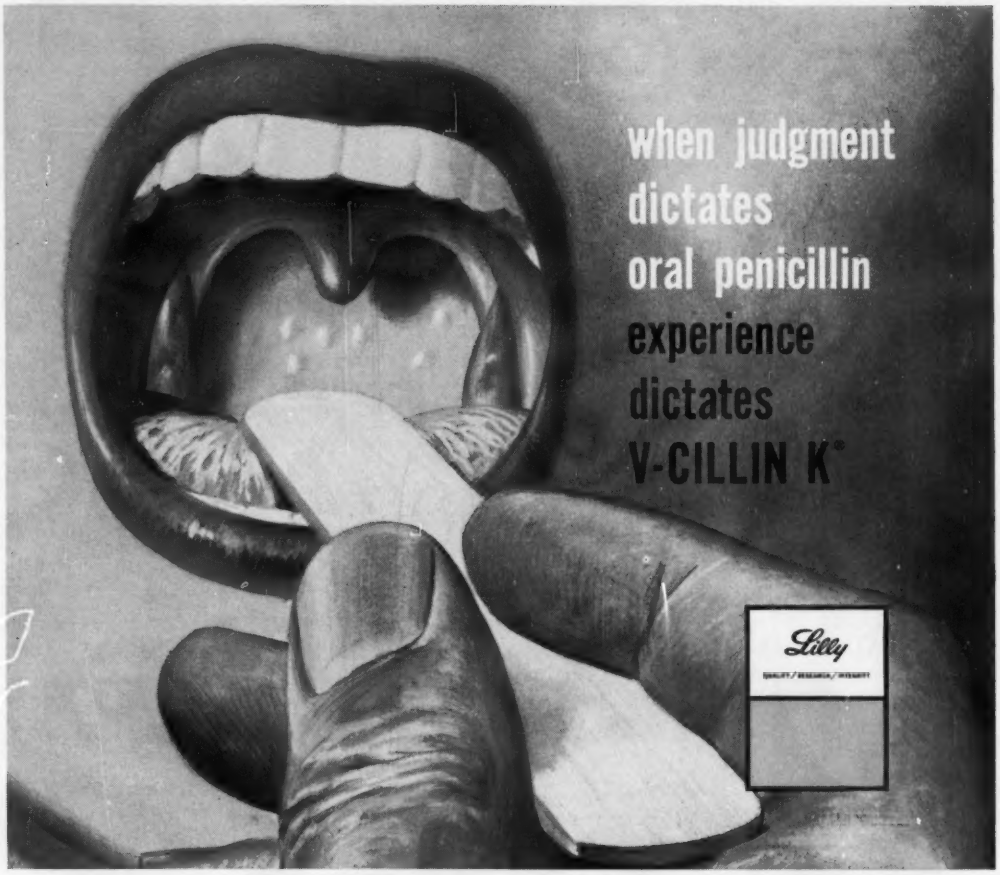

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for unmatched speed Peak levels of antibacterial activity are attained within fifteen to thirty minutes—faster than with any other oral penicillin.[1]

for unsurpassed safety The excellent safety record of V-Cillin K is well established. There is no evidence available to show that any form of penicillin is less allergenic or less toxic than V-Cillin K.

Prescribe V-Cillin K in scored tablets of 125 and 250 mg., or V-Cillin K, Pediatric, in 40 and 80-cc. bottles.

1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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Foreword About Aging Articles

IN A RECENT report to the World Health Organization, specialists from Brazil, Canada, the Soviet Union, Sweden, Switzerland, and The Netherlands criticized the tendency to exaggerate the perils of the increase in the number of older persons.

Governments, universities, the labor unions, the Junior League, and a variety of other agencies, as diversified as those named, are all attacking what is called, "The Problem of the Aged."

More recreation, medical care subsidy, special housing, and a list of baby-sitter-type provisions are among the suggestions for those whom we tenderly call "Senior Citizens."

It appears to the Geriatric Committee of the Michigan State Medical Society that an artificial problem is being created through artificial provisions of the economy.

It is recognized that retirement is forced on many men and women at an age when they are still physically and mentally fit to continue as productive citizens.

While the span of healthy years is increased by medical science, others arbitrarily have reduced the working years.

Many of our own neighbors who have been classified as "too old to hire" are actually younger than the President of the United States and many other prominent governmental, industrial, business, and cultural leaders of the world. It is only justice to allow older men and women to keep on working to preserve their independence and dignity.

Investigations and inquiries show that there is just one predominant complaint from our "Senior Citizens," that of boredom.

This issue of THE JOURNAL of the Michigan State Medical Society is dedicated to the concept that most of our "Senior Citizens" are well and normal people. We must not deprive them of the active constructive lives they are capable of enjoying.

* * *

Dr. Norman Vincent Peale tells this story:

Somewhere in the South, across from a filling station, there is a sign which reads, "Fortunes Told that Guarantee the Future."

A motorist stopped and asked the attendant about it one day. He was told that an old colored woman lived there who was something of a local celebrity. "Everything she touches perks up," he added.

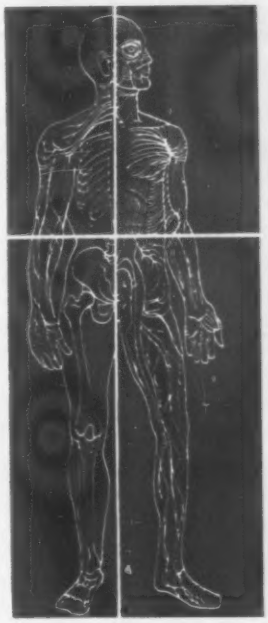
The traveler was feeling very despondent, and though he had little faith in fortune tellers, he paid her a visit.

"Put out yo' hand, Honey," he was instructed; and he did.

The old woman peered intently at the lines.

"Honey," she said, "You ain't done livin', yet!"

That was all he got for his money, and he drove away feeling cheated, but those words kept going round and round in his mind, and gradually that vital thought penctrated his depression and let in new hope and optimism.



Old Age: The Completion of a Life Cycle

Thomas N. Rudd, M.D., F.R.C.P.
London, England

I

IN THE RECENT history of Public Health, three clear stages can be defined: the stage of modern sanitation, which led to the control of epidemic disease, the stage of maternity and child welfare, and the present stage, in which the predominant problems are those of old age. In facing today's difficulties, it is worth asking ourselves how the earlier triumphs of public health were gained.

Slums have been greatly reduced in Western countries, and those who lived in such conditions have improved in health and in social behavior. Epidemic disease is greatly reduced and infectious disease hospitals have been turned over to other purposes. Maternity and child health can show similar advances; never has childbirth been safer or juvenile health more assured. The results are manifest in personal well-being, in statistics and in our under-crowded pediatric wards.

The credit for all this does not lie with the doctors or the politicians. The doctor's part has largely consisted of "mopping-up operations." Nor can the legislature be given all the praise: in fact, no early law or regulation has made any difference.

The common factor of the early advances seems to have been an upsurge in the public conscience, a refusal to allow more inhumanity of man to man, or to allow certain conditions of living to be perpetuated. Small examples, repeated over a widening area, stirred public consciousness until it was fully awake, and with enlightened public opinion, medical and social science could advance with legal support.

THE AUTHOR

Thomas N. Rudd, M.D., F.R.C.P.

There is no reason to believe that it can be otherwise in the matter of old-age care. Concentrated efforts thus far hardly have touched the problem, which in fact seems to grow faster than the remedy. What has happened is the introduction of a new and unperceived factor—the view, begun by politicians and too readily accepted by the electorate, that the State can and should solve the problem. It is now clear to the most obtuse politician that the State cannot; but voters are too emotionally involved to renounce such a comfortable idea. Organised religion, too often content with saying heart-easing things, so far hasn't spoken. We are therefore facing a snowball situation of increasing magnitude, the size of which we cannot lessen because we are trying in the wrong way. It is not that our tools are too large or too small; it is simply that they are not the right ones to use.

II

Modern conditions tend to make most of us live on the surface, unaware of our turbulent unconscious desire. It is these latter, in ourselves and in our patients, which are creating the geriatric problem. "Perhaps the most outstanding threat to the aged is the attitude of the surrounding culture towards ageing itself. Many western cultures tend toward an attitude of elder-rejection. Such cultural exclusion of the elderly is based upon sociological characteristics which add up mainly to overemphasis of the values of youth and youthfulness. The ageing person . . . often develops a sense of minority exclusion. Since the older person has himself contributed and participated in these social attitudes, he experiences a psychological phenomenon, immanent in ageing, which may be termed self-rejection."[1] The process is more or less unconscious, but the more unconscious it is, the more will the person turn from old age as unpleasant, dirty and burdensome, with perhaps a compensatory over-concern with childhood and youth.

Excerpted from *The Journal of the American Geriatrics Society*, Volume VI, Number 1, with permission of Williams and Wilkins Company, publisher.

Dr. Rudd is consultant physician of the Geriatric Unit, Southampton General Hospital.

A widespread attitude such as this is highly inconvenient to the needy aged who want help quickly, as well as frustrating for the enlightened members of the community who are planning, not only for those who are already old, but for their elder-rejecting contemporaries who may themselves be in need in another ten years' time. But these ill-effects are small compared with the danger of such attitudes, for it is these very attitudes which precipitate the psychiatric ill-health, the major threat to happiness and security in the declining years of life. Clearly, a major work of reorientation is necessary. The problems of old age have to be faced, not only by the nation which considers a burden in terms of increased taxation, but by every single person.

III

Many people behave as if the life's work is accomplished between the ages of sixteen and sixty-five, childhood being merely a time of preparation, and the function of education to impart knowledge which will increase earning capacity. It is the adult life which matters, and when retirement is reached, the only consolation is to shine among the neighbours as one who has been financially successful. Failing this, one can only mark time, awaiting death. Such a concept is comparatively new—two or three hundred years old at the outside—and was preceded by centuries when life was regarded as an entity, a complete thing, its constituent stages being of equal value in the sight of God. By this philosophy, life was reckoned as a whole, with each stage having its characteristic attitudes, its own lessons to be learned, its own dangers to be faced, and its own contribution to make to the life of the community. That old age is as much a necessary stage as childhood needs to be emphasized.

The fundamental difficulty in completing the last stage of growing up is the extremely unattractive picture which we have made old age present. As Jung continues, "A human being would certainly not grow to be seventy or eighty years old if this longevity had no meaning for the species to which he belongs."[2] We paint age as undesirable on many counts; we overstress its dependency and undervalue the cultural gifts which old age can bring. But this very dependency is not in itself an entirely undesirable thing. Like other things, including a refusal to accept one's limitations, it is ambivalent, capable of being beautiful or ugly, depending on how it is practised. As to the cultural values of age, however much we may despise them, they are part of the heritage of our civilisation. It is to our elders that we owe our deep feeling, so easily lost in the competitive turmoil of active life, that the meaning of life transcends ambition and material success, and that true happiness is independent of both, that the religious teaching which brought us comfort in childhood remains valid even though we had forgotten it, and that our ability to learn willing renunciation of things we are certain to lose is as valuable a part of education as the acquisition of a trade skill. Nor is the maintenance of cultural values the only benefit age confers. The old are not nearly as useless as they and we often think. They contribute to the national economy directly as well as indirectly. Furthermore, as a recent speaker[3] has insisted, the stimulus they give to younger people to save for the future is such that if old age did not already exist, it would be necessary for a Chancellor of the Exchequer to invent it.

IV

It is an unfortunate thing that many people, doctors, nurses, social workers and even clergy, have very little understanding of what it feels like to be old. This is the reason for the defective approaches we so often find. We are all familiar with the antipathy which looks on old age as dirty and repellent, and the aged themselves as better dead. The patronage which fundamentally despises age and which talks down to it, is an equally sterile approach, unproductive of good because of the lack of identification between the parties concerned.

What is so easy to forget is that our feeling about ourselves do not fundamentally change as age advances, even though mentation may slow and memory begin to fail. We still retain our personalities and are hurt if they are ignored. It is then no wonder that people who have throughout their lives grouped themselves into clubs and societies according to their interests and achievements should object to be classified into undifferentiated old people. It is in the neglect of the personality, that we who are doctors, nurses and social workers most surely fail. The practice of referring to our hospital patients by the group-names of "Pop" and "Grandad" is inconsiderate of them, as well as being hurtful to our own approach. Apart from respect, the aged have certain other needs in common with the younger age-groups. Above all, they need security. Volumes have been written on this need in children. To the aged also,

insecurity is a perpetual threat, in the realms of companionship, of place of residence, and of health.

Security of tenure in the home is, at least, in some degree under our control, if we will pay attention to the essential services which support home-care. Home-Helps, "Meals on Wheels," day-visitors and night-attendants all play their part in providing security. Residential hostels which provide sick rooms to avoid unnecessary admission to hospitals all do their duty, but these efforts will be ineffective if family doctor, nurse and home-matron have omitted to learn the art of nursing the elderly-frail. Many old people who are "problems" where they are living, would not be so if only someone would learn the technique of handling them.

A further need is the ability to choose, in itself merely an extension of courtesy to the personality. Choice is one of those things we must learn to relinquish as we age—the old person is well aware that in the big things of life he has little enough to say; to choose one's course in the little things is none the less healthy. If one cannot choose for oneself where to live, it is at least good to choose between tea and cocoa, between cheese and fruit, and whether to spend one's scanty pocket money on sweets or tobacco. Even the choice of a sitting-out place in a residential home helps to dispel apathy and senile dementia. Such choices can be arranged without difficulty by families and those who order the lives of dependent old people. When the choice is not offered, we have failed in our duty to our charges who depend on us.

Religious consideration is a further need. The loss of our religious sense is no reason to forget the strong religious feelings of others, especially the aged. In many old people, the religious sense is dormant, and may need arousing. It is, at any rate, not identical with that in younger people. Like everything else, it changes with the years. Thought becomes mellower and we view the present, not only in the light of the past, but especially in the light of the future. Old people may thus become more tolerant of other varieties of faith: they do not, however, become less "denominational" and we have no right to think that any kind of religion will do for them.

The reason for rejection of old age is not, however, the proximity of death, nor the quiet decline of our powers as we sing into mellow senescence: it is rather the brutal assaults which may suddenly come upon the personality, the sudden deprivation of faculties of speech, sight and movement and the loss of security and companionship. Some such are clearly inevitable; they are hazards common to all stages of life. In later years, these threats seem more menacing and their reality tends to obscure the fact that the danger is not inevitable. Realisation that these threats can often be averted and that ill health is the abnormal state rather than the normal, restores to us a sense of proportion. Only too often, faulty patterns of living during maturity, wrong eating, drinking and smoking, and even more importantly, faulty thinking, exert their effect during postretirement years. Even more important factors in ill health are the neurotic fears and tensions to which the modern world is prey. These are fundamental in producing not only frank anxiety states, but stress-conditions such as peptic ulcers, asthma, hypertension and other illnesses, the origins of which are now recognised as psychosomatic. Even senile dementia, formerly regarded as being arteriosclerotic, is now held to be primarily the result of emotional factors, the vascular changes being the "last straw" causing breakdown in an organ already overburdened by anxieties and stresses. Disability and ill-health are clearly not entirely preventable but can to a large extent be avoided by healthy living in early life and especially in the pre-senile years. Most important of all is a philosophy of life which excludes anxieties and which inculcates patience, cheerfulness and courage. Regarded in this way, advancing years present, not an inevitable threat, but a challenge to the whole personality to accept the fullness of experience, rather than to confine it for ever within the limitations of the middle years.

V

Once the philosophy of old age has been worked out, we are enabled to approach its problems rationally. We can now see old age as an essential stage both for the individual and the community, and think more of what old age is contributing (though often in silence) rather than the burden it is said to impose. The burden has been much exaggerated of late and the problems are, in fact, only insoluble if wrong methods are used.

The Welfare State's greatest contribution to modern thought is surely that legislation, aided by taxation, cannot solve problems whose basis is primarily moral. Of such nature are those we are now considering. When old people have families whose moral basis is sound, no problem really exists. The problem arises only (1) when a heavy load is falling on the only young members of the family, (2) when the old person has no younger relatives, or (3) when the family lacks a proper sense of responsibility. Medi-

cal and home-care services should normally be able to cope with the first group in their stride. The real stress and strain arises in the other two groups and it is with these people that the inadequacy of the Welfare State becomes manifest. These two groups comprise the lonely and rejected on whom fall the highest incidence of senile dementia. They are the frail, the mentally-deteriorated, the confused, and those unequal to independent living. They throng the wards of general, geriatric and mental hospitals, and present the greatest difficulty in discharge.

The difficulty is insoluble financially, for even if the enormous expansion of hospitals which the situation demands could be paid for, the additional nurses required could not be found in countries where there is full employment for women in the production of luxury goods. Highly-taxed communities are not only unwilling for further taxation, but are discovering that they have overstepped economic levels. Trades Unions demand higher wages, taxes increase, and the cost of living rises. In Britain, at least, a deadlock has been reached. Mental hospitals are overcrowded (largely with older people for whom no home can be found) to the point of inefficiency because the community at large is unprepared to make the sacrifices required. Nor are the real victims the only sufferers; the larger world cannot be unaffected by what is happening.

The well-being and proper care for the aged and mentally sick is not only a moral duty falling on the fit, but also a psychic necessity if the latter are to remain mentally fit. When the State is helpless, common sense and moral responsibility must assert themselves and take over. For too long have we answered the question "Am I my brother's keeper?" in the negative, pointing to the State as the responsible object.

The road back to individual responsibility will not be an easy one. The ground will need careful preparation by moral and religious leaders and a host of small examples will be required before the national conscience can be aroused. We can then await a solution to our present problems, with the same expectation with which our fathers awaited their success in the fields of hygiene and child care. Meanwhile, a start can be made by activating our own religious bodies, professional and industrial guilds to take greater responsibility for their ailing members. Medieval trading companies, such as the Merchant Venturers of Bristol and the great City of London Companies had a long tradition of charitable care, which modern Trades Unions could emulate. In assuming responsibility for their fellows, more Christians could follow the charitable example given by the Jewish faith: too often organised charitable work is left to Catholic Religious Communities and the Salvation Army. Until every thinking man of good will accepts a share in responsibility for others, the problems will remain unsolved. Comforts may have to be sacrificed and standards of living lowered, but against this we shall be able to set quiet consciences, a deepening of the personality and a chance of personal old age, untroubled by mental clouding.

VI

Old age may still hold sadness for us. That may be not only inevitable, but essential for our maturation. We shall still want to add life to years, but only so that life shall be filled with experience. We know that "there are no fields of amaranth on this side of the grave. There are no voices, O Rhodophe, however sweet, which are not soon silent. There is no name, with whatever emphasis of passionate love repeated, whose echo is not dim at last." We do not ask that life should be different; we only ask to be able to accept it, and to have such physical and mental health as will enable us to live it on the highest plane consistent with our experience and abilities.

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Retired Executives Organize

Retired executives in the San Francisco area have organized themselves into a group which advises small business. John S. Curran, a 74-year-old retired banker, is chairman of the group. He recommends the activity as a way of keeping fit and maintaining interests, as well as a source of great personal satisfaction. William B. Logan, a 37-year-old management consultant, originated the plan of operation. He is now helping top-flight retired executives in the San Diego area organize a group similar to the one now functioning in the Bay area.

How Well Are Old People?

Robert T. Monroe, M.D.
Boston, Massachusetts

HOW WELL are old people? To find the answer to this question has been a principal goal of the Age Center of New England. Now, after five years' search, it is in a state of informed confusion on the matter. Is "sick" the opposite of "well"? "Sick" and "old" at any age are terms that vary in meaning according to who uses them and for what purpose. There is the lad too sick to go to school but very active at home, the young thing repelled by the advances of an old man of thirty, the young man rejected by his draft board who did a great job in defense work, the old man unfit for his job who regains health promptly when employment returns, and the grandma who is short of breath when idle in her chair but full of life when there is opportunity to be of service.

If sickness is a pathologic state in some organ or tissue, then all old people are sick. When one considers all that can happen to the body through sixty years of interaction with this world of things and people, from canities to hemorrhoids, and at every location in between, one is forced to admit the impossibility of old age free from present disease or the scars of former diseases. And death, which is the extreme degree of sickness, is to be expected by all old people. Hunt[1] has pointed out that in 1955, 56.5 per cent of the deaths occurred in people over sixty-five, and another 25.8 per cent in people forty-five to sixty-four years old. Yet all reports persist in showing that less than 5 per cent of old people are confined to institutions of any sort and that the great majority of the rest consider themselves healthy and well. These diametrically opposed answers can only mean that different measuring devices are used.

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Physicians employ one set of measures. Our whole training is toward the identification and alleviation of illness. We would do well to be alert to how constricted this focus is. We have noticed how our friends at ordinary social gatherings regale us with their medical experiences, in the apparent belief that we can have no topic of greater interest. This should make us suspect that our patients, in hospital, office or home, tell us only what they want us to hear. Their focus ranges over their total selves as objects greater than their ills. They would like to be free to choose when to resort to a physician, free to select him, and free to follow or to reject his advice. How much they tell him depends on their perception of him as a safe counsellor and of their situation as likely to be helped. They get a great deal of their diagnoses, interpretations and courage from friends and relatives. Many of them feel at a disadvantage on physical examination, some feel over-awed by modern medical tests, few escape the delusion that by these means we know all that we need to about them.

The study methods of the Age Center of New England were designed to permit people to describe themselves as fully as possible. Our "core" studies have been on a group of independent, self-motivated, apparently healthy aging men and women. They pay a small annual fee for membership and submit voluntarily to a great many interviews which describe all aspects of their lives and to a number of psychological tests. They are told that this is for research, that no service is offered, no physical examination done and no diagnosis or treatment given. They are described as our authorities who come to us to give us the facts by which we can define their group. To our gratified surprise, they have come in adequate numbers, and most of those who join have continued with us.

The Cornell Medical Index Health Questionnaire, produced and copyrighted by Cornell Medical School, was adopted as an instrument that might tell us well

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what the members think about their symptoms and illnesses. It consists of 195 questions which are checked yes or no privately by the member, and requires on the average less than half an hour to complete. It is discussed with the member at a later interview when his general health and medical experiences are more fully set down. When the request came for this paper, the results of a study of 536 CMI tests were being analyzed for publication elsewhere. Since the present deadline is the more imminent, we shall now deal largely with impressions and conclusions.

How sick is this healthy aging group? They are active enough to come to us, mostly by public transportation, involving forty-four subway steps, two city blocks to the second floor of a hotel (the hotel elevator usually is scorned), at a cost to themselves of at least forty cents. They have the reputation, in bad weather, of being a little more reliable than the staff in keeping appointments. They have had a little more than average amount of formal education. They seem to have been successful and financially independent most of their lives, although very few of them are well-to-do by today's dollars. We suspect that they dress for their Age Center interviews with more than ordinary care and neatness, but we have a feeling that this is more an expression of habitual self-respect than any possible deference to us. They clearly are in charge of themselves. Many are fully occupied and involved in affairs, many others are looking for new activities. They appear to appreciate both the opportunity to contribute to researches and to work out their problems in their own ways. About 16 per cent of them are less than sixty years old; 44 per cent are between sixty and seventy; 32 per cent are between seventy and eighty; and 7 per cent are over eighty years of age. We agree with them that they are healthy and we have good hopes that they can fairly represent the situation of many people of their age elsewhere in the country.

These 536 individuals had, on the average, several times more affirmative answers to the Cornell Medical Index questions of symptoms and facts than have been reported for young adults. Women had distinctly higher scores than men in every category. But there was no tendency for the scores to increase progressively with age. The highest scores, in fact, were among the early aging group, up to sixty-five years; those over eighty years of age scored less than the average for the whole group. It is tempting to say that this is because the older people have forgotten or are denying their troubles, but these evasions are by no means confined to old people. They will be discussed further on. The soundest explanation seems to be that the early aging individuals were more actively concerned with present threats and anxieties in business and at home and therefore were more conscious of bodily interferences, whereas the older individuals had passed beyond them or escaped them.

A review of the responses also suggests that elapsed time is the chief reason for the scores being higher than in young adult life—a lot happens and accumulates in forty to sixty years. In the somatic disease categories this becomes clear: Practically every one in the group wore glasses. One in seven were hard of hearing. Many had chronic disorders of the upper respiratory tract, but very few had asthma or hay fever. About 20 per cent had been told by their doctors that their blood pressure was too high, but almost as many had been told by the same authority that it was too low. One in eight had been told that they had heart trouble and even more had cramps in the legs. More than 50 per cent had lost more than half their teeth. Twelve per cent of the men and 6 per cent of the women had been told that they had stomach ulcers. About one in ten had constipation and had had jaundice. Muscle and joint troubles were experienced by about one in every twenty men and one in every eight women. More than 10 per cent had fainted occasionally and also had been "knocked unconscious." One fourth of the women had vivid recollections of menstrual troubles. Ten per cent of the men had been treated for what may have been venereal disease, and one-third of them had had a hernia. Half of both men and women had nocturia. One fourth of them had had scarlet fever and one tenth may have had rheumatic fever. Five per cent of the men and 25 per cent of the women had been treated for anemia. Only 3 per cent had diabetes. Eight per cent of the men and 21 per cent of the women had been "treated for tumor or cancer." Only 8 per cent of the men and 14 per cent of the women "suffer from any chronic disease." About 10 per cent were underweight in their opinion and more than 20 per cent were overweight. One in five had varicose veins, and about one in six had had a "serious injury." Almost exactly half of the men and women had had a "serious operation."

It is possible that these average experiences with symptoms do not tell as clearly as they might do what the existing state of health—or sickness—of these old people really is. To get further light, a physician and a psychiatrist were asked to consider each of the 195 questions as to their importance—or

threat—to the responder, and to rank them on a 1 to 5 scale. Of course it turned out that the two often disagreed, so a third party put together those where he thought the agreement was strong, and there were 102 of them. Eight per cent of the men and almost 5 per cent of the women had no "yes" answers to any of them. Most of them had one to five "yes" answers, but 16 per cent of the men and 34 per cent of the women had more than eleven. One woman affably agreed to eighty-six questions, several agreed to more than fifty, yet they are members in good standing of this healthy group.

How much of a burden are these people on the medical profession? Forty-six of them asserted that they have no physician or don't believe in them; their average Cornell Medical Index scores were about half of the scores for the whole group. Seventy-eight did not answer and were not pressed for one. Twenty-four used clinics in teaching hospitals and 390 had their own doctors. But very often they had not seen their doctor for years, or he was one that they had never seen but might call on in need. Only a small percentage of them submitted to regular check-up examinations. How often they visited their doctors appeared to depend as much on the doctor's style of practicing medicine as it did on the patient's need. Thus one woman had been persuaded to join a clinic which was conducting studies on osteoporosis. She went to it faithfully and when other symptoms appeared, she was referred to other clinics also. As time went on, the advised visits became so frequent that she acted as a volunteer worker in the hospital to simplify her schedule. When she came to the Age Center, the hospital reported that she was a hypochondriac, absorbed in her symptoms, but her version was that she was merely obeying orders and would be greatly relieved to have less medical attention.

The Age Center has corresponded with the physicians of its members, when permitted, to get their point of view on the health and safety of their patients. The replies have been courteous, prompt and amusing. Most of them are to the effect that there was nothing wrong with this person when last seen. Only one advised us not to add to his patient's heavy schedule. Around twenty of my own patients have joined the Center. In my office, they are healthy except for specific details, but on the Cornell Medical Index, they often answer questions affirmatively which surprise me. I am convicted of being supportive or blind, but I suspect my colleagues are also.

Some of the members have ready recall of symptoms, illnesses and accidents no matter how far back in the past. Others do not, and women as often as men. Women who during the greater part of their adult lives spent one fourth of their time with menstrual distresses and the rest of the time getting over or looking forward to them, may be excused if in their old age they still respond affirmatively to questions about them; but some answered in the negative. At the present stage of our studies, it is our impression that the factors determining responses are not the quantity and quality of troubles so much as character variables—sturdiness, security, confidence (these ordinary words leave our psychiatrists and psychologists free to use their own more specific terminology).

The members respond variably to the challenges in the questions, "if you can answer yes," "if you have to answer no," "usually," "constantly," "suffer." Many who had had fractures denied "serious injury." For some, a "serious operation" was a tonsillectomy or hemorrhoidectomy; others said no because their cholecystectomy or herniorrhaphy was uneventful. One man who was able, in narrow truth, to deny questions as to nervousness had had a series of electro-shock treatments. Another man of eighty years could say "no" to pain in the chest; at sixty he had many severe anginal attacks while his wife was dying and his business failing; but he remarried, started a new business, and now is successful, happy and free from chest pain. Personality variables again seem to prevail. One person cooperates with every question and overstates his case. Another meticulously crosses out a word or adds a qualifying phrase ("sometimes," "yes, but don't suffer"). Still another seems to resent exposing a soft spot in his armor and so denies all that he can. The only difference between all of them and a younger group seems to be the complexity of personality that time and experience create. All of them associate with us for months as healthy and normal individuals.

The responses of these members to the fifty questions on inadequacy, depression, anxiety, sensitivity, anger and tension were also several times more often affirmative than has been reported for normal young adults. Much research needs to be done to determine why this is so. Undoubtedly, some of our members have been disturbed all their lives and have made such adjustments as they could, with success enough to pass for "healthy" and "independent" and "self-motivated." Some of the most secure individuals have been buffeted severely by grief, by loss and by change. One is enormously complex, another is simple and natural in coping with whatever comes along.

Culture, family mores, religion, the work-a-day world give support here and cause stress there. The capacity to act, to choose, to dare, to feel, is not only the current balance between all sorts of psychological systems at superficial and deep levels; it is also the steadily diminishing sum of living central nervous system cells and pathways.

There was the member who had retired ten years ago after teaching the same grade in the same school for forty-five years, who had lived in the same apartment with the same sister for sixty years, who had never had a day off for illness and could recall no class that was outstandingly good or bad, and who has no problems now. Was she healthy? How will she behave when trouble comes? There was the member who built up an engineering company from pennies to prominence in his middle years and at the same time became much sought after in community and charitable projects. Yet, during a space of ten years, he had to spend at least half of his time in a hospital for the pre-antibiotic care of osteomyelitis. Was he sick? One cheerful, friendly man of eighty who in retirement from teaching had made a significant career as an author, admitted with unanticipated agitation, "I never got over the loss of my wife thirty-eight years ago. I keep trying to adjust."

The somatic and psychological experiences of an individual strongly influence the confident and disciplined use of his body. More precisely, the balance of available physical processes remaining from a life-time of combat with environment and of available memories, habits, perceptions and central nervous association systems constitutes physical and mental fitness in old age. Old people have more than the young to be sick with and sick of, yet they call themselves well if they view their balance as satisfactory and sick when they find it less so. The optimistic over-all picture given by Dr. Ethel Shanas[2] is fully justified. Individually, "as a man thinketh in his heart, so is he."

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Stockpiling Virus Vaccines

Stockpiling influenza vaccine for use against future epidemics is possible now, says a University of Michigan virus researcher, because of a composite vaccine which is effective against a wide variety of flu strains.

Fred M. Davenport, M.D., professor of epidemiology at the U-M School of Public Health and director of the Commission on Influenza of the Armed Forces Epidemiological Board, believes the nation should build such stockpiles, although he admits it would entail a "calculated risk."

The alternative, he says, is an endless series of crash programs to fight each new form of influenza.

The value of a multiple vaccine is somewhat controversial because of disagreement on the nature of changes which occur in the flu virus. Some investigators say the virus changes from year to year in an endless variety, and maintain that any vaccine for existing strains of the disease would quickly become outdated.

Others, including Dr. Davenport, believe the various strains can be cataloged under six major "families" of viruses, and that these recur in cycles. The U-M researchers currently are working with a composite vaccine which protects against the six families of flu virus. Elements of all six are combined in a mineral oil emulsion. Dr. Davenport says this vaccine should protect a person for about three years.

The "Very Sick" in the Older Population

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THE POPULATION of the United States sixty-five years of age and older is now at about fifteen and one-half million persons. Between 3 and 5 per cent of these people are in institutions; the remainder are living in the community. It is with those older people living in the community that this report is concerned.

Medical examinations would undoubtedly discover pathology of some kind in many of the fifteen million older people who live in their own homes. The presence or absence of such pathology among the aged, however, cannot be employed as a criterion of the use which older people now make of medical services. In general, older people who use medical care are those older people who think they are sick. Obviously, these self-definitions of what is sickness vary from individual to individual. Most physicians have seen in their practices both older persons with acute illnesses who did not feel that they needed medical attention and older persons who were sure that they were much sicker than the doctor thought they were.

How sick are older people?† Despite extensive self-reports of specific diseases and general physical complaints, most older people think their health is good. A minority of older people think they are sick, and a still smaller group think they are "very sick."

How large is the "very sick" group in the older population? Using self-reports of diseases and physical complaints as a basis of estimation, the "very sick" group in the non-institutional population aged sixty-five and over is estimated at between 10 and 14 per cent, or from 1,550,000 to 2,170,000 persons. These estimates are derived from a study of the health needs of older people made by the National Opinion Research Center of the University of Chicago under a grant from the Health Information Foundation. In this study, using methods comparable to those employed by the United States Census Bureau, a sample of all older people in the United States who were not in institutions was located and interviewed in the spring of 1957.

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Ten per cent of all persons interviewed in the National Opinion Research Center study may be considered in the "very sick" group. If those people located in the general population who were "too sick to be interviewed" are added to this group, the proportion of the "very sick" in the older population rises to 14 per cent. The "very sick" in the older population are estimated to be from 9 to 11 per cent of those aged sixty-five to seventy-four years, or about one in every ten in this age-group, and from 14 to 20 per cent of those aged seventy-five years and over, or at most about two in every ten. The lower proportions are based only on those interviewed in the study; the higher proportions include those "too sick to be interviewed" but located in the non-institutional population.

The "very sick" differ from the rest of the older population in their general characteristics, and they differ in many of their attitudes toward health and medical care. The "very sick" are more likely to be women than men; they tend to be at the older end of the sixty-five-and-over group; and, if they have children, they are more likely to live with these children than is true for the remainder of the older population. Two of every three of the "very sick" group are women; four of every ten are seventy-five years of age and older. In the remainder of the older population, only half are women, and only three of

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†See Ethel Shanas, "How Sick Are Older People?," *Journal of the American Medical Association*, pp. 169-170, January 9, 1960.

every ten are seventy-five years of age and over. Among those who are "very sick" and who have children, 44 per cent live in the same household with at least one child. In the remainder of the older population with living children, 35 per cent live in the same household with at least one child.

The "very sick" group are a lower income group than the remainder of the older population. Thirty-seven per cent of the "very sick," compared to 11 per cent of the remainder of the older population, report Old Age Assistance or Welfare as their main source of income. Only 18 per cent of the "very sick," compared to 41 per cent of the remainder of the aged, report that they have health or hospital insurance.

Some of the attitudes of the "very sick" group toward health and medical care may be of special interest to physicians. Seventy-one per cent of the "very sick" feel their health is poor. Fifty-four per cent feel that their health is worse than the health of other people their age; and 37 per cent are worried about their health. In the other nine-tenths of the older population only 13 per cent feel their health is poor, only 9 per cent feel their health is worse than that of other people their age, and only 12 per cent report that something about their health worries them.

The small group of the aged who, on the basis of self-reports, appeared to be the "sickest," reported extensive use of medical services. These persons, who were only 10 per cent of the older population interviewed, were almost 20 per cent of those who had seen a doctor during the four-week period preceding the interview, 24 per cent of those who had seen a doctor in their own homes during this time-period, and 31 per cent of those who reported that they had had to make special arrangements in their way of life because of their health—they had to have special diets, or take regular "shots," or make arrangements to have someone do their shopping or household chores.

Those older persons who come to the physician's attention help form his conception of older people and their needs. In a four-week period about 20 per cent of the older people whom the doctor will see will be among the "very sick." Eighty per cent of his older patients, however, will come from the much larger group in the population who consider themselves as basically healthy.

The comparisons between the self-reported "very sick" and the remainder of the older population indicate that these "very sick" represent an extreme group. Because physicians dealing with the aged see all segments of the older population, doctors should be less likely than the general public to attribute the characteristics of the small "very sick" group to all older people.

Gall-bladder Study Found Valuable Despite Jaundice

X-ray visualization of the gall bladder with the contrast agent Telepaque is feasible and valuable even when jaundice is present, and routine use of the procedure may be advisable to evaluate all cases of jaundice.

These, and other conclusions, are made by Lt. Phillip H. Meyers and Lt. Richard W. Barr, both USNR, based on clinical studies at the United States Naval Hospital, Quantico, Va. They report on four cases of suspected infectious hepatitis with jaundice.

The investigators call attention to the fact that stones were demonstrated "in two of our patients suspected of having infectious hepatitis with jaundice, and in whom there had been no symptoms or physical signs to suggest cholelithiasis."

They say adequate visualization can be expected in 85 per cent of cases of infectious hepatitis, especially those with a mild increase of bilirubin in the blood.—*American Journal of Roentgenology, Radium Therapy and Nuclear Medicine*, 82:1028, 1959.

A Stitch in Time

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DEATH CAME, as it must to all men, to 257 physicians whose names were listed in the obituary sections of two recent issues of the *Journal of the AMA*. Eighty-two, or almost a third of our 257 good doctors had reached eighty or more; twenty-one had lived into their nineties. More than two-thirds of the physicians listed were more than sixty-five years of age.

This is an encouraging reflection of the golden age of medicine in which our population now lives. It emphasizes the extension of a full and useful life span with positive living among older persons which medical science has made possible.

Those of us, who are familiar with the retirement habits of doctors, know, without further analysis, that most of these men did not sit and wait for death. They were stricken while in the vineyard of service to others. They were active among their fellow men. They were wanted and felt wanted and needed. They had not been placed on the shelf by modern society like so many others, through forced retirement systems.

The great majority or our people today arrive at the age of sixty-five or seventy in essentially good health. These people need, above all else, the continued opportunity and incentive to use their health and capabilities to the fullest. One of the earliest findings of the American Medical Association's Committee on Aging was that there were no diseases related specifically to chronological age. Recognizing that the primary need is for fitness through active use of capacities among all persons, young and old, the Committee has emphasized the importance of the individual's assuming responsibility for his own health—for his *using* the knowledge of exercise, nutrition and healthful living habits now available in order to achieve in Pollock's words, "maximum longevity for his inherited biological strength."

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The Committee has encouraged physicians to act as health counselors as well as healers to their own patients of all ages—to help these patients develop and follow health maintenance programs suited to their individual needs. As a basis upon which such a health counseling program could be built, the Committee has developed a Periodic Health appraisal form for use by physicians with their patients, particularly those of middle and older years. This form goes beyond the traditional scope of a physical examination in that it is designed not only to obtain an orderly history and physical findings by systems, but to elicit information on exercise and rest habits, dietary practices, recreation, social and family environment, and emotional problems.

This Health Appraisal form can enable the physician to prescribe for *health* as well as sickness. It can help him not only to detect disease or predisposition to disease but to correct any dietary, exercise, emotional or social factors which could in time lead to more serious illness. Many lives have been saved through the early recognition of changes in body physiology which seemed so minor that the patient did not attach sufficient importance to them to seek medical advice or treatment. Too often these early signs are found by accident and too often they are not found sufficiently early.

A systematic approach to periodic health appraisal with adequate records is essential to good medical practice in all age groups. It yields the richest dividends in the middle and senior years when more things are likely to require attention. Those of us who are required to travel a great deal by air derive considerable comfort and reassurance from the knowledge that maintenance crews routinely check aircraft en-

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gines after stated hours of flying time. We can hardly justify waiting until the human machine actually breaks down before we are motivated to action toward prolonging its smooth operation.

The wry comment has often been made that the physician prescribes for others, but never for himself. This emphasizes a basic fact which holds true for all persons: knowledge alone, of health, healthful living habits, and prevention of diseases, is not enough; it becomes valuable only insofar as each individual applies this knowledge in his own life.

One would think that the physician, with the accumulated heritage from generations of medical thinking at his command, with sophisticated knowledge of health, disease and disease prevention, would be among the last to succumb to the degenerative diseases of the heart, blood vessels, and other organs of the body which loom so large in mortality statistics today. Yet, how often do we set the example for our patients through the application of optimum diet and physical exercise? How often do we practice what we preach?

Along with everyone else, we use every conceivable gadget to avoid effort and exertion. Not only do we ride in cars, we don't use our muscles to steer, open the window or apply the brake. We use escalators instead of steps and "golfmobiles" instead of our legs on the golf course. Yet, many of us still eat as if all the world's machinery had to be moved with our muscles. The evidence is mounting that these abuses carry a penalty in terms of degenerative diseases, cardio-vascular disorders and atherosclerosis.

The physician is in a position to set the example for his patients through his own observance of optimum health practices including careful physical examinations at regular intervals. "A stitch in time saves nine" only if one looks for the place where it is needed and not if there is delay until the defect becomes obvious. After many hours of study and conference with other interested groups, the members of our Committee are convinced that the average span of life could be lengthened materially through the application of scientific knowledge presently available to us. If we apply this knowledge to ourselves more effectively, our patients might well follow our example. Moreover, the added years can be transformed into years of positive living and enjoyment.

Retirement based on chronological age is a killer of men. Unless one has something to retire to, it leads to despair through a feeling of rejection and a functional atrophy or mental capabilities through disuse. It magnifies chronic diseases and defects through boredom and depression. It results in a flagrant waste of highly capable man power in America today. Compulsory retirement systems can rarely be justified on the basis of performance.

There is a great need for the American physician to assume a leadership role in redirecting the public attitude toward aging. The negative approach has emphasized increasing helplessness, dependence and inactivity with each passing year after sixty or sixty-five. Let us not become reconciled to the illusion that we need more and more beds for more and more sick and helpless old people. Let us apply the knowledge we have to show the way to a new era of physical and mental alertness throughout life; in increasing growth and maturity for more old people who are well and productive. Let us set an example to society through health maintenance standards within our own profession worthy of their emulation. Physician, heal thyself!

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SFPOGGWTR

Inglewood's (Calif.) *News-Advertiser* published the following letter in its April 26, 1959, issue: "The initials are: SFPOGGWTR, or the Society for the Prevention of Giving Gold Watches to Retirees. Of all the cruel and misguided gestures, this is about the worst. Of all times when a man least needs a reminder of time it is when he leaves a busy normal workaday world and has nothing but time on his hands. It is sad enough when a man, who may still have health, ability and experience to carry on, must leave his job because he reaches a certain age. As he deteriorates in his idleness, the gold watch only serves to make him feel how useless he has become. Besides, any man who has had to arrive on the job on time year after year, already has one or more watches."

Health and Retirement

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ONE OF THE most significant and widely acclaimed achievements of Western industrial society has been the provision of larger and larger segments of leisure time for all. Yet, this accomplishment is often seen as a mixed blessing. Particularly in the case of retirement, it is argued that the attendant problems render this less a major accomplishment and more a deplorable by-product of the industrial order.

Among the alleged negative effects of retirement, the most serious would seem to be the negative effect on health. Although the process whereby retirement affects health has not been specified, there is widespread agreement that such effects exist and that they probably are in some manner associated with the abrupt cessation of patterns of activity to which the organism had become adapted through many years on the job. What is the evidence on which such an impression is based?

First of all, everyone—professional and layman alike—knows of specific cases in which an apparently healthy person retires and almost immediately suffers a radical decline in health or, in fact, dies. Without denying the possibility that illness or death in such instances may be correctly attributed to retirement shock, for the gerontologist who attempts to understand the general effects of retirement, such evidence must be rejected as inconclusive. In the first place, the single case could never legitimately be used as a basis for generalization. Moreover, most people also know of specific cases in which no such decline occurs. The negative case is simply the more salient, the more easily remembered. Appraisal of retirement on the basis of such evidence we call *the fallacy of the dramatic instance.*

Such instances become more impressive, however, when multiplied many times over. The files of every geriatrician are replete with cases which reveal the coincidence of retirement and a decline in health. Yet this, too, must be rejected as inconclusive evidence as to the general effects of retirement. While the number of cases may be impressive, they most probably represent the unhealthy portion of the population, not the retired population as a whole, and thus provide no basis for valid generalization. That is to say, the illusion is one of a grossly debilitated older population; the fact is one of limited contact with a self selected portion of that population. Appraisal of retirement on the basis of such evidence we call *the fallacy of the clinical perspective.*

It would appear, then, that a correct understanding of the overall effects of retirement on health requires a rigorous sampling of the retired population so as to insure representativeness. But this alone is not enough. Some, but not all, of the retired decline in health; but so, in fact, do those who are gainfully employed. The epidemiological problem thus becomes one of comparing the working and the retired population to determine whether the latter is characterized by a disproportionately large incidence of poor health.

At first glance, evidence from such comparisons would seem to provide the basis for judging retirement a killer. Even when age is held constant, a higher frequency of poor health consistently is found among samples of the retired as compared with the gainfully employed. But is there a higher incidence of poor health because these people retired, or did they retire because they were in poor health? Although precisely representative of the retired and the working population at a given time, cross sectional comparisons never can provide the answer to this "chicken or egg" question. Appraisal of retirement on the basis of such evidence involves *the fallacy of ceteris paribus*—in this case, the assumption that the working and the retired samples were equal in health prior to the latter's retiring.

The difficulties inherent in these limited perspectives are obviated by the panel, or longitudinal, study design. Ideally, the panel design involves representative sampling of a given population and repeated contacts of this same sample over a period of time. Thus it is possible not only to make comparisons of a particular characteristic at a given time—as in the case of the cross sectional design described above—but also to make comparisons of changes that occur between

From the Department of Sociology and Anthropology, Cornell University, Ithaca, New York.

points in time. With respect to the effects of retirement on health, the panel design provides an answer to the following question: given a certain condition of health among people all of whom are gainfully employed, is a decline in health more likely among those who retire than among those who continue working? Similarly, of course, the panel design provides an answer to the question of whether health is more likely to improve among those who retire than among those who continue working. Initial contact provides the baseline from which changes can be measured; subsequent contact enables one to determine whether such changes occur with greater frequency among those who meanwhile retired than among those who continued working.

The Cornell Study of Occupational Retirement attempts to assess the effects of retirement through the use of such a research design.* More specifically, starting in 1952 at which time all of the respondents in the Cornell Study were gainfully employed, we have completed four subsequent contacts of nearly 2,000 members of the original panel. While the major emphasis of this research has been on attitudinal and adjustment changes as indexed by a sociological questionnaire, questions were included in that questionnaire which seek the respondents' evaluation of their health. In addition, medical inventories were completed by a majority and complete physical examinations were given nearly 500 of the respondents. The Cornell Study departs from the ideal of the panel study design in that practical administrative considerations made it impossible to secure a sample representative of America's older population. Generalization, therefore, should be limited to the Study population. The ability to study changes through time, however, provides a unique perspective on the relationship between retirement and health.

Findings of the Cornell Study

The findings consistently refute the notion that, in general, retirement leads to a decline in health. Although a simple comparison of the retired with their gainfully employed counterparts shows a higher incidence of poor health among the retirees (and thus is consistent with other cross sectional analyses), when pre-retirement health is held constant and changes are compared, it appears that those who retire are somewhat less likely to decline in health. (Table I). In fact,

TABLE I. SHIFTS IN HEALTH (SELF-APPRAISAL) AMONG THOSE WHO HAD RETIRED BY 1954 AND THOSE WHO CONTINUED WORKING THROUGHOUT
(Analysis Limited to Males Who Were 63 to 65 Years of Age in 1952)

	Shifts in Health Ratings:		
	Became Better	Did Not Change	Became Worse
Retired (477 cases):			
Between 1952 and 1954	33%	41%	26%
Between 1954 and 1956	32%	44%	24%
Gainfully employed (783 cases):			
Between 1952 and 1954	25%	44%	31%
Between 1954 and 1956	26%	43%	31%

the retirees are somewhat more likely to improve in health. The point is this: the retirees as a whole are less healthy than the gainfully employed of the same age, but they were also less healthy as a group before they retired. In fact, the evidence suggests that many retire because of their poor health. The effects of retirement, if any at all, are to increase the chances of recovery through less exertion, more rest and the like.

These findings, of course, are subject to the charge that an individual's self-evaluation of health is not "really" an adequate index.** Absence of a relationship between retirement and health, however, is revealed also in analysis of more objective appraisals. Thus, for example, the examining physicians were asked to rate the health of the respondents on a 5-point scale ranging from very poor to excellent. Among those rated as "good" or "excellent" in 1952, 20 per cent had declined in health by 1954 among those who had retired as compared with 18 per cent among those who had continued working. But among those rated as "fair," "poor" or "very poor" in 1952, 58 per cent of the retirees improved in health as compared with only 36 per cent of those who continued working.

Finally, a similar pattern is revealed in preliminary analysis of the review of the medical examinations made by the Cornell Study's medical consultant. Here,

*For a more complete statement regarding the Cornell Study of Occupational Retirement, see Gordon F. Streib, Wayne E. Thompson and Edward A. Suchman: The Cornell Study of Occupational Retirement. *The Journal of Social Issues*, 14:3-17, 1958. This same journal also includes a fuller statement of the Cornell findings relating to retirement and health. See Wayne E. Thompson and Gordon F. Streib: Situational Determinants: Health and Economic Deprivation in Retirement. Pp. 18-34.

**The question of adequacy, of course, requires further specification: adequate for what purposes? For an analysis of the relationships between objective and subjective indices of health as used in the Cornell Study of Occupational Retirement, see Edward A. Suchman, Bernard S. Phillips and Gordon F. Streib: An Analysis of the Validity of Health Questionnaires. *Social Forces*, 36:223-232, 1958.

as a summary evaluation both of the self-administered medical inventories and the more detailed physical examinations, the reviewer was asked to rate the condition of the respondent on a 4-point scale: normal; condition present but not serious; serious condition but stable; and serious and progressive condition.† In the early examination of these data, the most striking result appears to be the predominance of "normal" ratings in every category. Change analysis shows moreover a tendency toward improved health conditions—a tendency toward the normal—through the years of the study.

Selecting as a case in point the summary evaluation of the physician's evaluation of the cardio-vascular system, we find that among those who retired between 1952 and 1954 the condition of 53 per cent remained stable, 26 per cent worsened, and 21 per cent improved in health. The figures for those who continued working are 43 per cent, 27 per cent and 30 per cent, respectively. Between 1954 and 1956, among this same group of retirees, 55 per cent remained stable, 16 per cent worsened, and 29 per cent improved in their health condition. This compares with 57 per cent of the gainfully employed who remained stable; but in this latter group 23 per cent worsened and only 20 per cent improved.

The safest conclusion here, of course, is that no relationship has been revealed between retirement and health. In its consistency with the self-health appraisals and the examining physician's overall evaluation, however, one is tempted to infer that the summary evaluation suggests the hypothesis that, if anything at all, retirement leads to an improvement in health, not a decline.

†This was done for each of the following nine systematic categories: eyes, ears-nose-throat, respiratory, cardio-vascular, gastro-intestinal, genito-urinary, musculo-skeletal, central nervous (including psychiatric) and endocrine. A more detailed analysis of these data will be forthcoming, representing primarily the contribution of the Study's medical consultant, Dr. Kenneth E. Monroe.

Summary

What then do these findings reveal? First of all, although not reported explicitly here, one garners the impression that there is a surprisingly high incidence of good health among the older persons included in this Study. As we have emphasized above, it is not possible for us to generalize to the older population as a whole although there is some evidence to indicate that in many respects the Study population does not significantly depart from the characteristics of the total population of like age.

Be that as it may, the cross sectional analysis of the study findings parallel those of other studies: retirees are, as a group, less healthy than the gainfully employed. But the panel design of the Study shows this to reflect the fact that people who are in poor health tend to retire, not that retirement leads to a decline in health. Overall, in fact, if anything, it would appear that retirement as compared to continued gainful employment may lead to improvement in health.

What the findings do not reveal, of course, is evidence regarding the individual case. Our survey research findings enable one to talk about retirement, not about the individual retiree. But to know about retirement as a social process may help to place in proper perspective one's approach to the individual retiree. To the extent that expectations cause or contribute to illness, the health of the individual may be served by a correct, broader understanding; for this broader perspective can transform the frightening spectre of retirement to an image of opportunity and fulfillment—an image both for the individual and for society of a rich harvest and a rightful reward.

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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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1. Innerfield, I.: Clinical report cited with permission
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The Geriatrician Meets Gramps from Podunk

C. Howard Ross, M.D.
Ann Arbor, Michigan

WHEN SPRIGHTLY "Podunk" floats before one's consciousness, there is an awareness of elderly isolation, whether it be at the geographical four corners or the spiritual seclusion of a great city. The majority of old people can paddle along so well because they have outlived their enemies and their disasters.

By one means or another, the golden-age person presents himself for examination. On many occasions, the first interview may be in the home. Here the physician becomes aware of "living under one's own steam" or a possible "secondary citizenship," chaperoned by the younger generation. He also notes the "frugality of existence" or the "comforts of old age" earned by careful planning in previous years. Are tobacco and beer smells the remarkable ingredients of the atmosphere?

The relationship between the two generations is quickly revealed. Some grandmothers like to talk about death and the grave and enjoy watching their "wicked descendants" squirm in an abyss of guilt.

The chief complaint and recording of history could well hide a bolder cause of the call. One must draw out hidden details. Thus a productive cough with sputum for perusal, may be admitted, but the raising of blood comes to the front only following some juggling of conversation. Also, much fearful emphasis is poured out in confession upon some lesser detail that only borders on the status of health, like retinal image retention before sleep.

In reverse, the physician may become an agent of confusion, if too much emphasis is placed upon routine findings of age such as *arcus senilis*.

A typical day's diet is reviewed, and proteins and vitamins are scanned for their inclusion.

Eventually, there comes the examination. Cleanliness, quality of hair and skin are noted. Is there bold evidence of anemia? Should blood studies be made at once? Much is learned from personal housekeeping. Bathroom odors on the person are signicant from the standpoints of physical neglect, spiritual letdown or constitutional incapacity.

The scalp or face may reveal blemishes of early carcinomatous manifestation. One dwells at the eyes, inspects the glasses for "fit" and reading service and inquires as to the identity of ophthalmologist and date of last visit. The ears may reveal a large mass of cerumen, aggravating the incapacity of hearing. The nose cannot be passed by lightly. I have found large plugs of blood and dried mucus that were relieved by the application of vaseline and warm fomentations and the discouragement of the inquiring finger.

The mouth and throat should be carefully investigated for mucous membrane pathology and voice sounds. The teeth, if any, plus prosthesis, deserve intimate evaluation. A few old snags with foul gums and evidences of devitalization certainly demand urgent dental attention. Good chew must attack good food.

The thyroid gland is palpated before and after the swallow. A hard nodule, or mass of goitre, deserves laboratory follow-up in the form of basal metabolism determination and protein bound iodine level before proper referral.

The chest is reviewed for symmetry and nutrition. The breasts of men and women should be palpated for masses. I have found early carcinoma in both breasts, even in the nineties. The lungs are a favorite hunting ground. The absence of sound in an isolated area is as significant as a whole battery of rales. Moist rales at the bases may be the first hint of congestive failure. The many details of pulmonary examination will not be given, but I urge

THE AUTHOR
C. Howard Ross, M.D.

performance and diligence. Could pneumonia or tuberculosis or bronchiogenic carcinoma be lurking there? An x-ray requisition is an easy entity to flash and sign.

The heart is examined for size, function and murmurs in mitral, pulmonary and aortic zones. A thyroid nodule and tachycardia may go hand in hand. For mild exercise in the office, I merely have the patient leave the examination table for height and weight measurements, and upon return re-check the heart for rate, rhythm and possible murmur accentuation.

A vigorous man in his eighties with a functional murmur should not be alarmed. However, a younger man in his sixties or seventies, with pre-cordial pain, radiating down the left arm, may require coronary dilators, ambulance, hospitalization, E.K.G. and anti-coagulant regimen. Again I emphasize congestive failure in early or hidden form.

Blood pressure in the elderly is an adventure in itself. A nightwatchman of eighty years with a pressure of 220/120 need not be taken off his job, but one of the Rauwolfia alkaloids may become his friend for the duration of life. A diastolic pressure as high as 100 without albuminuria or physical incapacity may well be tolerated. A systolic pressure reaching 180 without symptoms may be watched but not fretted over. A man in his nineties with a pressure of 120/80 cannot be in a bad way. If the situation is so alarming, what is he doing being alive?

Eventually, one must descend to the abdomen. Is the liver border palpable? Is there a mass in the epigastrium? Is there tenderness in the costovertebral angle? One studies for changes in contour, rigidity and rebound tenderness, attempting to correlate with digestive or genito-urinary complaints if any. Gastrointestinal x-ray investigation and intravenous pyelograms should not be jumped at too readily nor neglected if circumstance and symptoms so dictate.

Pelvic organs are often neglected. I have had the elderly complainer recite a gap of fifty years between the last baby and geriatric show of blood before an examining doctor intervened. Inspection, speculum employment and bimanual examination are musts with Papanicolaou cytological study a close follow-up.

The male is reviewed for evidences of disease and changes of contour. Rectal investigation must follow and be included in all pelvic examinations with emphasis placed upon prostatic contour. Enquiry is made as to urinary pattern, and laboratory follow-up is the next step.

The extremities and spine come in for more than a glance. Is there deformity, dysfunction, circulatory impairment or edema? Is a prosthesis worn? If not, is one indicated? Is there a place for physical medicine? An old hemiplegic may still bear some opportunity of rehabilitation. A hopeful attitude is indicated.

I find shoes are a great element of neglect. Old people with sloppy fitting slippers and a sliding rug on a slippery floor descend to their doom. Two pair of socks and a properly fitted pair of shoes may give a spring to an old man's step. The elderly patient must be cautioned regarding paring of corns and digging at nails. Many a gangrenous episode begins at such an easy introduction.

Cleanliness and caution are the watchwords. A large pair of bandage scissors in the doctor's hand will trim hoof-like nails, and a bit of emery paper will sand down the rough edges. The care of the feet is not an act of social degradation; all parts of the body are precious.

The reader, finding a gross omission in my geriatric review, is invited not to commit the same error himself.

In short, the physical examination of the elderly and time for consultation are two entities that should be met whole hog. I see no subtle substitute on the horizon. Let us do the big things that are evident and necessary. Only the wise man knows when to pooh-pooh. There is a miracle in every victory.

On many occasions, we must say again and again:

> "Mourn not for that which is lost, but rejoice for that which is left."
>
> "If you are only a 50 per cent man, be a good 50 per cent man!"
>
> "The stream of life is not always pointed toward the elderly but may well up from him."
>
> "The ancient one can contribute with his talents and enrich the community in which he lives."

Senior Citizens At Work

A study of 313 people aged 80 or over who were still earning money was made last year by S. L. Pressey, professor of psychology at Ohio State University. Twenty-three of the 313 were 90 years of age and included two clergymen, three physicians, three lawyers, and a 94-year-old woman who was a receptionist.

A Timely Note From Molly

Dear Doctor:

AUNT MARY is coming in for her appointment with you on Monday, and I want to tip you off that Uncle John, who is retired, turned sixty-five in January. They had been looking forward to this and thought they were prepared. Money-wise they are. . . . What they did not realize were the changes it would bring in the daily routine which both have followed since the day they were married. She, of course, has not retired (a housewife never retires). However, she no longer has the business of rushing to get him off to work in the morning, then going about her independent day as usual and looking forward to his coming home at night. In fact, having him around all day creates its own set of problems.

For him, the freedom from the demands of his job was a welcome relief at first—like a vacation. But as the days go by and there is nothing that he *has* to do—no fellow workers to greet him or ask his advice—he seems to have lost some of the old sense of self assurance.

They'll weather it, of course, as they have earlier changes, but if Aunt Mary seems bewildered, and asks more questions about "other things" than her physical health, it is because she's wondering how to go about making the retirement years "the best that's yet to be" for her and Uncle John.

You've seen them through some critical times, Doc, and as their doctor, they look to you as "priest and healer." I know that you can be a strong ally now in making this transition easier.

At the moment, I think they only need information and encouragement in finding opportunities to enjoy friends, to help others, to gain new knowledge and experience, to have fun, and to do things they never had enough time for in his working years.

In the back of Aunt Mary's mind, however, is the question of the later years when they won't be so spry, when housekeeping chores, shopping, cooking nourishing meals, or nursing John through illness may be beyond her strength.

She may have heard of social services, but she's proud, you know, and like most older people she would not be able to apply for them on her own behalf. "They've never wanted charity."

She will turn to you. Your job will be much easier if you are familiar with the wide range of these services and help her to understand and use them. They can provide answers to many of these questions.

For instance:

An odd occasional job can do wonders for Uncle John's morale.

A senior center where he can meet others who are "in the same boat;" who sing and dance and swim, compete in games, or putter with hobbies will not only get him out of the house so Aunt Mary can clean those cupboards, but can put a new spring in his step.

Adult classes in high schools and universities, with instruction on how to invest money and make wills, or learn new languages, can increase his ability to manage his own affairs.

A visit to a Family Service Society can relieve personal and family tension through skilled professional counseling.

A call by you or your patient to private agencies who provide homemakers, Meals on Wheels, a housekeeper for a few hours a week, transportation to clinics, can mean the difference between breaking up their home and going to an institution.

Closer contact with churches, and participation in church activities can bring solace and comfort. As you know, many churches support services in homes for the aged, hospitals, neighborhood centers, et cetera.

THE AUTHOR
Molly Guiney

"Molly" Guiney is a member of the metropolitan Detroit Committee on Aging.

Libraries, museums, and public parks and recreation programs, which are open to all, have many special features for the retired. Free golfing in Detroit is one example.

Those who know and work closely with older people in various settings stress the need to enable the older person *to find his way to deal with his problems* as long as he is capable. Increased knowledge and wise use of services can prevent unnecessary breakdown, can restore his ability to help himself and can at least make him more comfortable in situations which cannot be reversed.

Many are still in the dark about:

Income Resources such as Social Security, Government Pensions, Insurance programs to which they have contributed while working and are entitled to, but they must apply for them; Old Age Assistance, Public Welfare, and hospitalization which are available for those without sufficient funds.

Housing such as, liberalized mortgages which can be secured for building a new home or remodeling an old one through the Federal Housing Administration; local public housing developments which give special consideration to those with low incomes over sixty; private builders which are developing homes with attractive features for the retired.

Every community today has some resources for enriching the lives of senior adults—some communities have many. The trick is in knowing how to find them, and how and when to use them.

Did you know that nineteen cities in Michigan have special committees on aging and can supply a directory of services? In every city there is a United Community Services (they have different names) who can give full information on services. In rural areas, the Red Cross, the Grange, the University Extension Service or the County Health Department are good resources.

All this reminds me that when we're talking about the aging, we're really talking about ourselves, and I'd better come in for a check-up before long.

Sincerely,
"MOLLY"

Program for Upper Peninsula Medical Society Meeting in June

Friday, June 17

9:00 Registration and Exhibits
10:30 Harold Mankin, M.D., Mayo Clinic, Rochester, Minn.
"Anticoagulant Therapy"
10:50 Malcolm A. McCannel, M.D., Minneapolis, Minn.
"Some Common Misconceptions about the Eye"
11:10 Lowell Peterson, M.D., Assistant Professor of Obstetrics and Gynecology, University of Illinois
"Lesions of the Cervix"
11:30 Discuss above talks
12:00 Exhibits
12:30 Lunch—House of Ludington

* * *

2:00 Fred J. Ansfield, M.D., Assistant Professor of Surgery, University of Wisconsin Cancer Research Hospital
"Cancer Chemotherapy"
2:20 Stuart M. Finch, M.D., Director—Children's Psychiatric Hospital, University of Michigan Medical Center
"Adolescence"
2:40 Carl Moyer, M.D., Professor of Surgery, Washington University School of Medicine, St. Louis, Mo.
"Fluid Balance"
3:00 Discussion of above talks
3:45 Lowell Peterson, M.D.
"Demonstration of Forceps Delivery on Manikin"
4:30 Exhibits

* * *

6:00 Cocktail Hour
Courtesy Delta-Schoolcraft County Medical Society
7:00 Smorgasbord—House of Ludington
9:30 Orchestra and Dance—House of Ludington

Saturday, June 18

9:00 Registration and Exhibits
10:00 Dr. Geo. Curry lecture by Frank H. Mayfield, M.D., University of Cincinnati Medical School Department of Neuro Surgery
"The Management of Head Injuries"
10:20 C. Edward Stepan, M.D., Chicago, Illinois
"Allergy Diseases in Children"
10:40 Rich. L. Rapport, M.D., Flint, Mich.
"The Fractured Rib—A Significant Injury"
11:00 Discussion on above talks
11:30 Exhibits
12:00 Lunch—House of Ludington
Introduction of Wm. N. Hubbard, M.D., Dean, University of Michigan Medical School
Business Meeting—Upper Peninsula Medical Society

* * *

Afternoon Relaxation of Golf—Boating—Relaxation

* * *

6:00 Cocktails—House of Ludington
Courtesy, Michigan Medical Service
7:00 Annual Banquet—House of Ludington
Toastmaster—Jean Worth, Editor, *Escanaba Daily Press*
Main address—Ann Landers
Columnist of *Chicago Sun-Times*
9:30 Orchestra and Dance—House of Ludington

The Aged: Their Rights--Our Moral Responsibility

Samuel D. Shrut, Ph.D.
New York, New York

THE TRUE test of a society is how it treats its weaker members. The aged person, now generally considered to be a member of a minority group, has been victimized by neglects—legal, financial, and psychological—and by a depressing near-absence of social planning. Such neglects may well offer a striking commentary on our society with its steadily increasing numbers of the aged, more than 29,000 of whom are said to have reached their ninety-fifth year, and in which medical progress promises (threatens?) to increase longevity still more and consequently to further test society's conscience.

Between the respect shown the elderly by the Chinese and the life-shortening treatment accorded their aged by various Eskimo tribes[1] are many variations of attitudes toward, and treatment of, the aged by other cultural groups.[2,3] Generally, a culture will accord to its aged population a kind of treatment that corresponds roughly to the benefits that it can derive from them.[4]

Background of the Problem

The older person in our society has been found to need help in order to live with a greater degree of health, freedom from emotional stress and insecurity, material sufficiency, and creature comfort. Planning for this help has been significantly inadequate, although currently in the United States there is some de-emphasis of our former popular consideration of the aged as "barnacles on the Ship of State." Insurance companies,[8] social service facilities of many communities,[6,9] and even some governmental agencies[5,7] are now increasingly concerning themselves with some thoughtful planning for and with the aged.

A review of the status of the aged in the United States is appropriate at this time, all the more so because of their increasing numbers. While in the past fifty years the population of the United States has doubled, the number of persons sixty-five years and older has quadrupled. Whereas in 1900, one out of twenty-five persons in this country was sixty-five and older, today one out of every eleven is in that group, with the percentages increasing persistently. The statement from a Government publication[10] sums up the population situation succinctly:

> The big increase in the relative number of older persons is the result largely of gains in control of infectious diseases, other advances in the fields of prevention and medical care, and of the general rise in the standard of living. Fewer people die in childhood or in their early adult years; more live to reach their sixties and seventies.*

Economics.—In one most important area, the situation seems to be growing worse. Work opportunities for the older groups have declined decidedly. There is an increasing practice in commerce and industry to retire employees at a fixed age, regardless of the psychologic, physiologic and economic injustice to the compulsorily retired worker. The tight labor market of World War II accounted for the sharp rise in employment of aged persons, but by the end of 1957†

This is a partial report of a doctoral study, "Old Age and Death Attitudes," undertaken at New York University under the direction of Professor Edward L. Kemp, and conducted at The Home for Aged and Infirm Hebrews of New York, under the supervision of Dr. F. D. Zeman, Chief of Medical Services, and Dr. Alvin I. Goldfarb, Chief of Neuropsychiatry at The Home.

*It is of more than passing interest to note that in India, for example, the problem of the aged is practically nonexistent, since the average life span is approximately thirty years and comparatively few survive beyond that age.

It is also estimated that by 1970 there will be in the U.S.A. a surplus of six million women of sixty-five and over as compared with men. Most women are widowed at the average age of fifty-one, with a life expectancy of approximately twenty years more, adding problems not only of singleness but also of employment and economic subsistence.

Remarriage following the death of a spouse is much more common among men. Also, aged men, if and when they marry, do so on a basis of the "inverse ratio," which means that the older the man, the younger will be his bride.

†Whereas in 1890 the country's labor force sixty-five years of age and older represented 4.3 per cent of the total population, it had changed to about 4.8 per cent in 1950. During this period, the percentage of persons sixty-five and older was nearly doubled (3.9 to 7.7 per cent) with the general increase of population in this country. The trend of employment of elderly men has been steadily downward, while employment of women, of all age groups, has increased.

there was a definite sag in the employment prospects of elderly workers.

The near-poverty that many of our older persons face may be high-lighted by the following considerations: in 1950, at a time when the median annual income was almost $1,971, about 43 per cent of all families headed by a person sixty-five and older had an annual income of less than $1,500; 30 per cent had an income under $1,000; and 15 per cent had an income of less than $500. The economic fate of the aged person living alone or with non-relatives was even worse, with three out of four such persons having an annual cash income of less than $500.[10,11] Then there is the estimate that three out of four aged persons are without hospital insurance.[10] Considering the health inadequacies of aged persons to be about two and one-half times greater than those of younger people, there is the strongly suggested need for a health insurance program. In brief, although the aged are considered a minority group, their large numbers are constantly increasing. Although many of them are employable, they are more frequently than not categorically denied employment; and although their health needs are greater than those of the younger generation, they seldom have the resources for proper health care.

Housing.—All this has direct implications as to where and how the older person lives. Despite the general misconception that most aged persons live in institutions for the aged, seven out of every ten elderly persons (or 9,000,000 of the 11,000,000 aged persons) lived in their own households in 1951. Of the currently estimated 3,000 homes for the aged in the United States,[12] Zeman[13] points out that between 1850 and 1900 nearly 500 such institutions were established by private philanthropies. Under the pressure of the increasing population of the aged facing fewer opportunities for supporting their longer life spans, a number of these homes have developed fine physical plants and good administrative practices and techniques of every kind. These homes have done much to reduce the long-standing stigma of social inferiority of institutions for older persons and to create a kindly environment as well as better physical care. Yet, in spite of this, only about 700,000 persons sixty-five years and older (5 per cent) live in homes for the aged.[11] This might well indicate the older persons desire for self-determination, demonstrated by (ingrained) resistance to the loss of independent residence even in institutional settings where respectful and considerate treatment are taken for granted.

The elderly person's attitude toward his environment is therefore of paramount importance in the thoughtful planning of present and future institutions. Basically, the question of how and where an older person lives is related to the degree and manner of planning for the future. Is residence under varying restrictive and/or protective institutional conditions related to the individual's feeling about his own future? Is this feeling linked with thoughts of death? Is there any inter-relationship between his attitude towards death, his estimates of the state of his health, and his response to the life around him?

Special Research on Housing

Answers to some of the foregoing questions were sought in a study[14] (of which this paper is a part) which attempted to investigate attitudes of older persons towards aging. As an index to this, attitude toward death was chosen on the assumption that attitude toward death is a reflection of attitude toward living. It was hypothesized that elderly people living in a way comparable to their former independent status in the community would be less fearful of death and more easily adjusted to the life around them. Their attitudes towards death, therefore, were appraised in relation to their own opinions of their health, activity, and general adjustment.

Sixty persons, ambulatory white women, currently unmarried, thirty living in the Apartment Residence* of the Home for Aged and Infirm Hebrews were studied in comparison with thirty persons from the more traditionally supervised and regulated Central House** of the same institution. Basically, the difference between the two kinds of living arrangements is that those living in the Apartment Residence live very much like other elderly people in the community, while those in Central House live in a building set somewhat apart from the regular residential neighborhood. The explicit differences are that in the Apartment Residence there are minimal supervision, independent activity, and private and better-appointed rooms (often with arrangements for serving snacks). In contrast, Central House has ward accommodations, organized activity, and other supervisory details of institutional living.

Both groups of residents were volunteers and were selected from a stratified sample after consultation with the Medical and Social Service departments of the Home. Subjects participated in the study on the basis that the research might have an effect on housing plans for older people and were assured that they would remain anonymous.

*Situated at 302 West 87th Street, New York City.
**Situated at 121 West 105th Street, New York City.

The experimental design of the study consisted of comparing the two groups by means of a psychological test battery of instruments which, except for the Thematic Apperception Test, were especially devised, along with their respective rating scales, by this investigator. The instruments, in order of their standardized presentation, were as follows:

Questionnaire on self-appraisal of health
Questionnaire for adjustment in the Home
Sentence-completion test
Thematic Apperception Test
Questionnaire on claimed participation in activities
Summary scoring for attitudes toward death

Some brief statements about the various instruments in the battery are in order.

The health questionnaire was designed to elicit information on past and current medical history for the self-rating of health, on the basis of five categories ranging from "excellent" to "very poor."

The questionnaire on adjustment consisted of seventeen detailed questions relating to food, supervision, rules and general interpersonal relationships of the resident in the institution.

The questionnaire on claimed participation in activities consisted of a series of detailed questions of possible activities involving physical and social pursuits in which the aged respondent may claim to take part.

A sentence-completion test and ten TAT cards were also utilized.

Specific rating scales were devised for each of these instruments, each based on a 5-point range. Ratings were made by various categories of judges (a physician, 3 psychologists, at least 3 social workers), who rated protocols blind and made pertinent judgments of subjects, who were represented by code numbers to assure anonymity. These ratings were then averaged for the various groups of judges and comparisons were made. However, only the averaged ratings of the 3 psychologists-judges were employed in evaluating attitude toward death (or attitude towards living).

Findings of the Research

The study disclosed that:

1. The elderly persons living in the Apartment Residence under conditions not greatly unlike their previous independent way of living in the community enjoyed better mental health, being less seclusive and suspicious, and showed less preoccupation with death, than the residents of Central House.

2. Residents of Central House indicated a less realistic estimate of their own health than the residents of the apartments.

3. The findings as to adjustment and claimed participation in activities for the two groups yielded no clearly drawn conclusions.

4. Respondents from the more permissive Apartment setting showed greater alertness in social matters and greater productivity than the Central House people. They also seemed able to cooperate more fully in the research program.

5. The sentence-completion test and the Thematic Apperception Test appeared to be more productive than the various instruments of the psychological test batteries in making psychological judgments of death attitudes. In this connection, both groups of subjects reveal mild anxiety, at least in regard to thoughts of death.

Further research is certainly needed to make the findings of the current study explicit. Some suggestions would be: a repetition of the same study in the same institution, with male subjects; similar studies with both men and women from other institutions, both sectarian and non-sectarian, and with various racial groups; a study comparing the population of apartment residences with non-residental care programs; and a long-term study of an aged population before their admission to an institution, and at periodic intervals thereafter.

Implications for Institutional Planning

Implicit in the present study's findings is the need for a de-emphasis in provision of mass-dwelling arrangements for aged persons. Instead, existing institutional facilities should attempt to provide within their settings, features affording the older person as much individual privacy as is practicable, so as to make possible a form of guidance, without interference. There should be provision for more private and semi-private rooms, or for small unsegregated cottage and small apartment plans incorporating details of convenience in living arrangements (shopping areas, theatres, schools, centers, et cetera).

Institutional residences, in whatever form they exist, need not be considered as terminal residences, but as places which the aged person may elect to leave for as long as desired, without forfeiting privileges of resumed residency. Although such provisions would not be without their increased financial costs and administrative complexities, these would be over-balanced by the

advantages in providing an easier and more satisfying mode of living. Furthermore, these new developments would enable the older person to remain in the community, by providing every assistance in maintaining a separate residence and perhaps even employment.

Support is also given to the recent development of "foster care" residency for aged persons, parallel to the similar though less recent development in the area of child care, with its abandonment of mass-housing arrangements.

Implicit in these findings is the realization that programs for older people designed to promote a kind of living approximating previous independent residence in the community have many advantages. Some of the advantages involve helping the aged individual to preserve self-esteem, thereby providing society with benefits that the aged person may yet contribute, and at the same time sparing the great emotional, social and financial expense that are such frequent concomitants of institutionalization.

Implications for the Educational and Psychosocial Aspects of the Elderly Person's Adjustment

Psychosocial research with the aged has long shown that individual hesitancy and disinterest in learning are due more to the aged person's own self-imposed restrictions than to his actual intellectual deficits. When the aged person feels himself squinting a bit more or finds himself asking someone to repeat a comment, he makes the additional inference that his "mind is failing." Although our culture has not been particularly sympathetic to persons beyond thirty continuing with serious educational efforts, many aged persons have demonstrated an ability to learn anything from nonsense syllables to a foreign language on a par with younger persons, even though at a somewhat reduced tempo. This is not to mention the feats of invention, literature, and statesmanship performed by elderly people. Along with the general acceptance that there is relatively little, if any, diminution in intellectual ability in older persons, there is the consensus of scientific thinking that, generally, the aged person's attitude, reflective of the cultural stereotype, stands in the way of new attempts at education or at learning new skills.

Furthermore, since attitude is usually reflective of the aged person's self-image, efforts at enabling the older person to maintain or retain a more flexible or youthful self-regard and resultant attitude is more than suggestive of the need for adequate, satisfying, and at best, casually-supervised independent housing arrangements.

Conclusions

Any research into an aspect of old age is faced by certain methodologic difficulties, and gives rise to some basic questions. Which of the "traits" usually ascribed to old age are endogenic, that is, organically determined, and thus typical for all old people? If these "traits" are not organically determined, to what extent are they basically affected by environmental conditions?

Much of the literature on old age concerns itself with what appears to be common-sense observations. There seems to be a neglect of the more subtle personality characteristics which reflect less what old age is, than what it turns out to be under insufficiently discriminating conditions.

From a review of the literature with its apparent preoccupation with the negative "traits" of old age, one finds it difficult to account for such persons as Bertrand Russell, Eleanor Roosevelt, Albert Schweitzer, Konrad Adenauer, Helen Keller, Grandma Moses, Judge Learned Hand, Winston Churchill, and many less prominent but comparable zestful examples of successful aging. Recent gerontologic studies have only begun to reveal what new attainments might possibly be attributable to old age under more appropriate societal conditions.

Both from the literature and the research on aging there is revealed that an institutional group is more rigid, has less drive, less spontaneity, and is less emotionally involved in activities and situations than is a group of older persons living in the community more or less on their own. Aged persons living under conditions simulating previous mode of independent residence in the community enjoy better mental health than their aged counterparts who are obliged to live under institutional settings. There is in this the strong suggestion of the necessity for a re-evaluation of institutional care, and for maintenance of older people in their own homes or in foster homes, and for a general attempt to enrich the lives of aged persons in their community settings.

Unless we are prepared to give these advantages, along with thoughtful planning, to our senior citizens, we shall deserve one critic's observation to the effect that America's juvenility is its oldest tradition.

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Senior Citizens Residence, Kalamazoo

Constance M. DeCair
Kalamazoo, Michigan

THE Senior Citizens Residence of Kalamazoo is providing gracious, apartment-type living for fifty older persons, and it will soon be able to increase its capacity to eighty-seven following the completion of an addition to the present unit.

What began in 1947 with a real concern by some of our citizens for better housing for the elderly has resulted in a concerted community effort to at least partially solve the local problem. At that time, the Mayor appointed a study committee which eventually resulted in the formation of the "Senior Citizens Fund," a charitable corporation to consider and endeavor to answer the problems of the aged. In 1949, the Senior Citizens Memorial Fund was established to receive contributions in honor of the living and in memory of friends and loved ones. Interest and response have continued to grow with monthly contributions now maintained at about $1500.00 a month.

In 1950, the Senior Citizens Fund merged its activities and program with Merrill-Home, Inc., which for many years had operated a home for elderly widows, and which had vacant property ideally located for an adjacent building. By 1953, we were ready to conduct a financial campaign for the long dreamed of new building. Generous gifts from individuals, corporations, bequests, and grants from the Kalamazoo Foundation, together with the memorial fund, finally totalled nearly $400,000 and construction of the new building proceeded. The first unit was opened in the summer of 1954, and was immediately filled with a carefully selected group of our older citizens for this new venture in group living. Applications far outnumbered the facilities and continue to do so.

In order to have sound operation of the venture, the Senior Citizens Fund is headed by five Trustees who have supervision and control over all property and assets. They are appointed for varying terms by the Circuit Court Judge, the Judge of the Probate Court, the past three presidents of the Community Chest, the Kalamazoo Foundation, and by the Board of Directors of the Fund. The Board is composed of thirty-five members who carry on the activities of the Corporation. Standing committees include the Executive, Building, Capital Fund Raising, Finance, Operating, Public Relations, Admissions, Medical, Recreation and Research. The Board has more of a function of making policies than the Trustees, and acts as the operational unit for the running of the residence. The staff is also supervised by the Operations Committee.

There are several unique features to the operation resulting from the belief of the Senior Citizens Board that the problems of the aged should not be restricted to the destitute or infirm alone. Frequently, the same problems can be found in the situation of any older person who finds himself in all too frequent isolation and loneliness. We have tried to provide companionship, independent living, stimulus, and fulfillment of interests, as well as relief from housekeeping cares. We try to concentrate on the active, able-bodied elderly person, with the hope that we may extend his period of activity and alertness and make the later years a happier period.

The location of the Residence is ideal, as it is situated close to the center of the city and within easy walking distance to the principal stores, the Mall, the library and museum, churches, theatres, the park and various recreational centers. The building is designed to insure a flexible pattern of living with an opportunity for self-expression and individuality. Each resident has a private room, equipped with a lavatory and toilet, a compact kitchen unit with refrigerator, stove, cupboard space, and exhaust fan, a

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telephone connected to the central switchboard, an air-conditioning unit, built-in television antenna, and a spacious closet. Individual lockers are provided in the trunk-room for additional storage. Automatic elevator service is provided.

(Above) Exterior view

(Below) Recreation room

Senior Citizens Residence, 1768 Greenlawn Avenue, Kalamazoo, Michigan

Residents are encouraged to incorporate some of their own personal effects to recreate a feeling of being really "at home." A great sense of security is created by the knowledge that a nurse makes the rounds once each hour during the night to insure everyone's well-being. Another safety precaution which enhances security is the use of hand-rails in the showers and bathubs and an emergency bell in the bathrooms in case anyone should need help.

One of the good end-products of this type of apartment living is the ease with which our residents can select either privacy or companionship as the mood indicates. Meals are served in an attractive cafeteria on the main floor and are planned especially to insure an adequate, balanced diet for older people. Our residents are encouraged to eat most of their meals in the dining room, although enough flexibility is allowed to permit a person to entertain, get breakfast, or a snack, in the individual's own room. There are few rules and even vacations are encouraged with a rebate given. Several of our younger people still drive their own cars. This seems to help a great deal toward combating any possible regimentation so often found in group living. It has been amazing to see how appetites and health have improved after a period in residence with companionship and stimulation at meal time. We, on the Admissions' Committee, have listened to too many heartbreaking stories of lonely old people who have reached the point where cooking for one was "too much trouble" and it was apparent that malnourishment was a foreseeable end-product of living alone.

Contributing to the living comforts of our people are the attractive lounge, equipped with TV, card tables, and the latest magazines; the recreation room in the basement, also with TV and facilities for crafts, group activities, and entertainment. Community groups frequently volunteer their services for concerts, moving pictures, and other entertainment. Also in the basement are free facilities for personal laundry, including an automatic washer, dryer, and steam

Present residents of Senior Citizens Residence

irons. In fair weather most of the residents avail themselves of the lawn chairs and many use the shuffleboard court next to the patio at the rear of the building. It seems as though the central location with its continual outside activity is a great source of pleasure to our residents who can feel that they are still in the busy stream of life.

Senior Citizens Residence does not provide life-time care as it is not a nursing or convalescent home, but we try to protect the health and welfare of our people by requiring a physical examination and chest x-ray prior to admission. We also maintain a small infirmary, staffed by practical nurses, for temporary care of minor illness and for the various health services so frequently needed by older people. We have found that the general health picture of our residents is extremely good and the infirmary is never filled to capacity and is more often vacant than not. The number of people who have left the home because of death or illness is comparatively small.

Our selection of new residents is carefuly worked out and involves several interviews, a physical examination, and the filling out of a comprehensive application form. Residents must be at least sixty years of age, although our median age at present is the early eighties. Three of our people are in the early nineties, two in the sixties, and fourteen in the seventies. We attempt to screen applicants so that we can maintain an age span covering many years, as we feel that the differential in age is a healthy device insuring a more vigorous home and providing a stimulation when younger, physically well people enter the group. Ideally, we would like to divide the age span so that 40 per cent would be in the seventies, 40 per cent in the eighties, and 20 per cent spread between the sixties and nineties.

We require that our residents be Kalamazoo people, as the Senior Citizens Residence is supported by the community. This is one way in which the city can, in a small measure, repay the life-time of giving which our people have contributed to the growth and welfare of our city. The cost of operating the residence is based on a monthly rate of $130.00 per person. This is all-inclusive—room with heat, meals, water, electricity, telephone, weekly housekeeping service and infirmary with nursing care for temporary illness. Some residents are financially able to meet the full charge, while others, who do not have as much, or are receiving state aid, are assisted through special gifts, bequests, and memorials to the Senior Citizens Fund, by individuals, organizations, and corporations. No down payment nor special commitment or obligation is required involving a resident's personal finances or estate. We attempt to select one-third of our residents who are financially independent, one-third with limited means, and one-third who must rely solely on State Aid. It is interesting that several former residents have remembered us generously in their wills.

Once a resident has joined our group we encourage

activities, new interests, part-time employment whenever feasible, and participation in the affairs of the community. One of our men continues his work as a silver engraver and clock repairman; one of our women expects to continue her job as a volunteer librarian; another sells Christmas cards and imported fabrics and has her room arranged as a living-room where she can continue her business. Another man, a former accountant, takes occasional bookkeeping or income tax jobs; several of our women have learned to operate the switchboard to assist in the office and earn a small salary. Another member, a registered nurse, has assisted the nursing staff on occasion. One of our women does personal laundry for the older, less active people, while still another carries on an active dressmaking and alteration program for the residents and board members. One of our men, possessing a "green thumb," formerly worked wonders with the flowers in the yard and was always available for minor repair jobs around the building.

We have been pleased that one of our women still teaches a large Sunday School Class for adults, while still another gives book reviews to clubs and organizations. Many of our women work on cancer dressings, work for political parties and cherish their right to vote, make Christmas decorations, sew and knit for charitable organizations, and engage in various crafts, both at the Residence and at our local "Drop-in Center." Religious affiliations are encouraged, although the Residence is non-sectarian and has had representatives of most of the faiths.

The future of the Senior Citizens project looks busy and encouraging as the old Merrill Home is to be torn down soon to make room for the beautiful new building with its expanded facilities and accommodations for forty-five more residents. We have had inquiries from several more couples who are anxious to live in the attractive larger apartments especially designed for two people, and are anticipating a revitalization of the whole structure with the welcome addition of these new people. Plans are under way for the engaging of an Executive Secretary, as we have grown into a big business which is demanding more than volunteers can give. We have been approached by another Home for the Aged to consider a possible merger of facilities, and are frequently asked by civic groups for help and advice on pertinent problems concerning the Senior Citizens of the community. We of the Board feel that our efforts have been most satisfying in helping to create a pioneer community plan which provides an abundant way of life for the elderly citizen.

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Two Universities Afford Older Adults Opportunities to Continue Learning

Hamilton Stillwell
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THIS IS a progress report on an experiment which is being undertaken by two universities to extend their rich educational resources to the older residents of the geographical area in which the two institutions are located. The test is only six months old and conclusive evidence is not available; however, what has been discovered in this short period is submitted for the information of those interested in the older adult and the manner in which he spends his new found leisure time.

The Division of Adult Education is a comparatively new educational unit which was established jointly by Wayne State University and The University of Michigan in 1957 to coordinate the non-credit educational activities of the two institutions in a six-county area in southeastern Michigan. The administrators of the Division discovered at the end of the academic year of 1958-59 that there were only three dozen adults sixty-five years of age or older among its 4,500 enrolled adults. With the knowledge that there were 250,000 older adults in the six-county area in which the Division operated, the administrators petitioned the two Universities for permission to lower tuition costs for older citizens for one year to see if this would increase their enrollment in the Division's courses.

The approved plan was that all adults sixty-five years of age or older would be allowed to enroll in any non-credit course offered by the Division through the payment of a $2.00 registration fee for each course taken. (The normal charge was $20.00 for a twelve week course.) The number of courses in which an individual might enroll was not limited but the number of such registrations in a course which had a limited enrollment could be restricted to five. Through this plan it was felt that the adult would have some financial stake in the course but the cost would not deprive him of the opportunity of enrollment.

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Results of the Publicity Given to the Experiment

The Division availed itself of every opportunity to publicize this new plan in late August and early September of 1959, and yet the effort should be described as the "soft-sell" approach rather than the "hard sell." Stories were carried in the daily and weekly newspapers and the Division's staff, when interviewed on radio programs, made mention of the new plan. A few, but certainly not all, social agencies which worked with older adults were apprised of the experiment. However, leaflets were not distributed or personal visits were not made to the usual haunts of the retired or aged.

The results of this quiet publicity campaign were soon evident. The Division received scores of telephone calls and dozens of oldsters stopped by the Division's office to discover further information about the policy. These numerous contacts indicated to the Division that the older members of our society are interested in continuing to learn. Of course, the types of courses offered by a university do not appeal to all adults. For example, many men were interested in courses in industrial arts and handicrafts, which courses are not offered by the Division. Many women also were more concerned with the avocational type of course—again not a university-level educational activity. Here the adults were referred to the public school adult education programs in the community.

An early dissatisfaction with the new policy was

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expressed by those who had retired but had not attained their sixty-fifth birthday. Another frequent comment was that as long as the majority of the courses were located on the college campus, they were inaccessible to the older citizen who found it difficult to travel from the suburbs or outer edges of the city. One senior citizen of eighty years remarked that he still drove his automobile but said, "I just don't want to get involved in getting on and off those expressways in Detroit." Another request was that more classes be scheduled during the daytime hours as this made travel easier for the older adult. Of course, the fact that most adult education classes are held in the evening poses a problem for those who are planning broad programs for the older citizens. Despite these criticisms, a sizable number of older persons indicated that they would register for one or more courses.

Enrollment Statistics

A decision made early by the staff of the Division was that it would not request any person who desired to register under the reduced fee policy to furnish proof of his or her age. This policy was adhered to and, although staff members had their doubts occasionally about the age of the registrants, the comparative youthfulness of some of the claiments for the reduced fee was attributed to the restorative powers of our modern drugs and dyes.

The enrollment of older adults in the Division's courses in the fall of 1959 increased 1300 per cent over the fall of 1958. Where there were just eleven individuals over the age of sixty, there were now 144 persons sixty-five years of age and older. Was the reduced fee the cause of this marked increase? Granted that added publicity was given to the fact that older citizens were welcome in the Division's courses, it still appears that the financial inducement was the major factor. The group definitely showed their interest in daytime classes when 33 per cent enrolled in afternoon classes which composed only eight per cent of the Division's total program. The older group also proved to be "bargain hunters" with 26 per cent enrolling in more than one course.

The previous educational level of the older students proved interesting and apparently far above the national average for this age group. Twenty-seven per cent of the older group were college graduates and 66 per cent had completed high school. An encouraging fact was that the group was rather evenly divided according to sex with 53 per cent being women and 47 per cent men.

The Division's registration form contains a space for occupation, although many did not complete this blank or merely replied "housewife" or "retired." Former occupations noted were: teachers, accountants, an engineer, a lawyer, a surgeon, a judge, and a newspaper publisher. Among the women thirteen, or 24 per cent, stated that they were widows.

Subject Interests

The Division did not establish special classes for the older group but encouraged them to enroll in the already constituted courses. Forty per cent of the group enrolled in such liberal arts courses as art, music and literature, thus enabling them to appreciate more fully the arts which they now had time to enjoy. Thirty senior citizens selected self-improvement subjects such as English composition, foreign languages, reading efficiency and creative writing. A goodly number also enrolled in self-understanding subjects such as psychology, philosophy and religion. Understandingly, the vocational subjects had little appeal, as the older adult no longer has this interest at his age. How teachable is this group is a question which cannot be answered at this time. There are many national tests to prove that adults continue to learn throughout life and the continued interest of the group indicates their obtaining satisfaction from the experience.

Observations of the Group

No study in depth of this group has been undertaken by the Division at this time. Certain generalizations can be made after the experience of six months. The older adult: (1) enjoys studying with all age groups and rather dislikes being placed just with "senior citizens," (2) prefers first floor locations and rooms with good lighting and comfortable furniture, (3) insists on professors being prompt and classes being held for the full class hour, (4) is not too confident about his ability to learn and needs encouragement by those who teach him, (5) welcomes counseling and advice during registration periods, (6) prefers daytime classes and classes located close to his residence, (7) has a social interest as well as an academic interest in his adult study, (8) is generally prompt himself and will be one of the first to register when the semester begins, (9) is most interested in the course which will aid him to utilize his leisure time in a constructive manner, (10) is slow to decide on his course and may wish to try more than one course before a decision is made.

Future Plans

At an afternoon tea which the Division sponsored for the over sixty-five-year age group in November of last fall, one of the participants stated that she hoped this plan would continue because it afforded older persons an opportunity "to re-exercise their areas of thought." Interviews and conversations with several of the participants indicated that the reduction in tuition costs was of great importance to the older adult, beset as he is with many other expenses. It was apparent that education was not one of the luxuries he could afford unless it came to him at a reasonable fee.

As this article is being written, registration for the spring semester in the Division has just closed. It was highly interesting to observe that 50 per cent of the older citizens re-registered for spring courses as compared to approximately 30 per cent of the younger adults. There are over 500,000 persons beyond the age of sixty-five years in Michigan and it is submitted that a large number of them believe that learning never ends. As long as they have that belief it behooves those of us in education to make our programs and facilities available at a time, place and fee most convenient to them. As the number of older adults in our population increases in the next decade from ten to fifteen per cent of our population, it is important that this large group have constructive uses for their vast amount of leisure time. Adjustment to retirement and leisure will occur much more easily if there are educational opportunities available.

Lung Cancer, Heart Disease Linked with Cigarette Smoking

Cigarette smoking, which has greatly increased in this country over the past few decades, is a "form of suicide, just as much so as shooting oneself," according to Dr. Alton Ochsner, professor of surgery, Tulane University School of Medicine (New Orleans), in an article in the March issue of the *Journal of the American Geriatrics Society*.

Dr. Ochsner cites excessive smoking as a major culprit in the development of carcinoma of the lung which, he states, "has become the most frequent of all cancers."

"In 1920, cancer of the lung represented 1.1 per cent of all cancers in the United States; in 1930, 2.2 per cent; in 1956, 10 per cent," he says.

Dr. Ochsner predicts that in 1976, unless something is done to prevent it, it will represent 30 per cent or more, that is, one out of every three cancers."

Dr. Ochsner also emphasizes the role of excessive smoking in the development of coronary disease. Noting that cancer of the lung is the only cancer which does not increase with advancing years, he gives as the reason the fact that heavy smokers have developed coronary thrombosis, and, as a result, "have not lived long enough to be afflicted with cancer of the lung."

Dr. Ochsner reports on a six-year study by the American Cancer Society involving 22,000 men between the ages of 50 and 70. The study showed that the over-all death rate among cigarette smokers was 105 per cent higher than among non-smokers. The death rate from heart disease was 115 per cent higher, and the death rate from cancer of the lung was 800 per cent higher!

The study revealed that "we have become a nation of heavy users of tobacco," Dr. Ochsner says. In the 65 and over age group, 20 per cent of the men had smoked a pack or more of cigarettes a day, whereas 21.6 per cent had never smoked. In the 50 to 54 year age group only 15 per cent had never smoked, whereas 43 per cent had smoked a pack or more a day.

Dr. Ochsner further notes that a recent poll among teenagers showed that among those aged 13 to 15 years inclusive, 37 per cent smoked, and among those aged 16 to 19 inclusive, 67 per cent smoked.

The Cancer Society study also showed a relationship between the amount smoked and the death rate. Whereas the death rate per 100,000 for the person who smoked half a pack a day was 51.4, it was 217 for over two packs.

Extensive studies in other countries also point to a causal relationship between smoking and lung cancer, Dr. Ochsner reveals. Moreover, such studies are documented by clinical evidence.

The Sixty-Five Club

David E. Snodgrass
San Francisco, California

TO MEMBERS of the medical profession, a law school may not seem to be quite the place for clinical research of any kind.

But at the University of California's Hastings College of Law in San Francisco we have been conducting clinical research of a sort for almost twenty years. And the results, from our point of view, have been extraordinarily good. Our objective was to determine whether law professors are too old and decrepit to teach effectively after reaching the age of sixty-five.

In embarking on our "research" project, we were acutely aware that most colleges and universities, like most business and industrial establishments, seem to operate on the principle that a person has outlived his usefulness when he reaches a predetermined age, usually sixty-five. Application of this principle means, of course, that careers are to be arbitrarily terminated at that age, without regard to physical, mental or professional fitness.

We at Hastings did not pretend to be scientific about the manner in which our "research" was conducted. We simply hired over-age professors, who had been uprooted by compulsory retirement rules at other law schools, and put them to work. After that, it was strictly a matter of observation and evaluation.

We did not require physical or psychiatric examinations. But we were carefully selective. After all, we were interested only in outstanding law teachers, men who had attained distinction in their profession and who were recognized nationally as authorities in their respective fields. Similarly, we were interested only in men still vigorous enough, mentally and physically, to carry normal teaching loads. But so far as that phase of our selective process is concerned, it was immaterial to us whether a prospect was sixty-five or seventy-five.

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As already indicated, our "research" has been eminently productive and eminently successful. We have demonstrated, at least to our satisfaction, the fallacy of compulsory retirement based on chronological age alone; so much so, that about ten years ago we adopted an ironclad rule against hiring anyone *under* the age of sixty-five for a full-time professorship.

We had to overcome a few obstacles, of course. What "clinical researcher" doesn't? During an early stage, we were heckled constantly by unenlightened critics who even challenged our basic premise. We repelled those attacks with substantially the same arguments which we use in spreading the gospel today. It seems to us that these arguments apply to government and business with just as much force as they do to the teaching profession.

First, we have an unshakeable conviction that chronological age is an unsound test for determining when a man should be retired, and that biological age should be the decisive factor. A man who is qualified, able, experienced and fit to continue with the same work in which he was engaged at sixty-four should not be deprived of the right to do so merely because he has had another birthday.

One man is too old to do effective work at fifty-five or sixty. Another is still approaching his peak of efficiency at sixty-five. History affords some dramatic illustrations.

Benjamin Franklin was seventy in 1776, when he sailed to France to interest that country in the American Revolution. In 1781, he helped to negotiate the only victorious peace in American history, at the age of seventy-five. Six years later, at eighty-one, he saved the Constitutional Convention. Yet in his day, the normal life expectancy of an American was only thirty-five years.

Winston Churchill attained his sixty-fifth birthday

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on November 30, 1939. What the consequences would have been if he had been required to leave the House of Commons on that date can only be left to speculation. Where might the Iron Curtain be now if he had been replaced by a younger man?

Economic problems are inherent in this matter of compulsory retirement, too. Every day, about 3,000 U. S. citizens turn sixty-five. It has been estimated that by 1975 there will be at least 20,000,000 persons in the United States who have attained that age.

The tax burdens of the country already are very heavy. Those which are attributed to Social Security, now 6 per cent, are likely to be doubled within a few years. Yet wage and salary earners are denied the privilege of enjoying the benefits of the program if they continue to work after sixty-five.

In my opinion, there is a great need for industry to develop flexible retirement programs. Industry does both itself and its workers a disservice by imposing retirement at a time when many employes are still capable of productive and satisfying service. Inflexible rules that deprive these workers of the right to be gainfully employed should be re-examined, in the interest of the common good.

Hastings, by reason of the fact that the College has no compulsory retirement age, has an ideal laboratory or proving ground for the theory that retirement should not depend on chronological age. The oldest and largest accredited law school on the Pacific Coast, it was founded in 1878 by Serranus Clinton Hastings, first Chief Justice of the California Supreme Court. Although repeatedly characterized by the Legislature as the Law Department of the University of California, it is governed by an independent board of directors, of which the Chief Justice of the California Supreme Court is ex officio president. Degrees are conferred by the University of California regents, on certification by the College directors. The foundation act says nothing about retirement.

Eventually, our galaxy of over-age professors was dubbed the "65 Club." The reaction was positive and the name stuck. It has become a familiar label among legal scholars throughout the world. In developing it, Hastings has attracted one of the finest law faculties ever assembled.

No so long ago, the great Roscoe Pound, Dean Emeritus of Harvard Law School and the grand old man of American legal education, was quoted by *Newsweek Magazine* as saying that on the whole he regards it as "the strongest law faculty in the country."

Another national magazine, *Coronet*, published a progress report on our "research" project some months ago, stating that we had:

". . . assembled a faculty of professors whose names are remembered with affection by generations of lawyers all over the country. They came from Yale, Harvard, Stanford and such great State Universities as Michigan and Illinois.

"And this eminent faculty began to attract students who might otherwise have gone to better-known law schools. . . . Hastings students are being taught by men whose collective experience, prestige and authority could hardly be matched at any other law school in the country. . . .

"The students have discovered that their professors are not only uniquely dedicated teachers, but that they are also more tolerant and understanding than most younger men would be. . . .

"The members of the '65 Club' are alert, brisk, vigorous and salty-tongued, and they are clearly getting a whale of a kick out of life. For they are doing what they like best."

Again, the *Harvard Law Record*, a weekly publication of Harvard Law School, in a tribute to members recruited from Harvard alumni described the "65 Club" as the country's "only Valhalla for elderly law professors" and noted that the membership has included some of "the leading luminaries in the gallery of legal stardom."

The most recent kudos came from a somewhat unexpected source, an inspection report on Hastings prepared by two representatives (both deans of approved law schools) of the American Bar Association.

This report, referring to the "65 Club," declared:

"The teaching ability of this group is beyond question. The productivity of these men is impressive, especially in view of their age. . . .

"There is no questioning the capacity and ability of this group. It includes some of the finest scholars and teachers in the United States. In view of the fact that they are all over sixty-five, we felt that age might have slowed them up.

"Consequently, we spent some time listening to those who had classes during our visit. The classroom performance in each instance was excellent. . . .

"Your evaluators are of the opinion that the faculty is alert, interested in and insisting upon high standards of legal education and doing an excellent job, not only in the classroom but in public service and research."

It seems appropriate to mention the fact that our Hastings oldsters have racked up an excellent attendance record, too. Year in and year out, they have missed fewer classes on account of illness than the average student. They are finished with diseases and their wives aren't having babies.

Perhaps a footnote should be added about how the "65 Club" happened and about its present membership.

Our "research" project did not begin as such. It stemmed from sheer necessity and was the product of emergency. Dean William M. Simmons, (fifty-five) died, with tragic suddenness, on August 25, 1940. A substitute had to be found for each of his three courses; and the academic year 1940-41 was less than five weeks off.

Younger men were unavailable, on such short notice. There was only one source of experienced teachers: the ranks of the compulsorily unemployed. Three months after giving his last lecture at the University of California School of Law (Berkeley), Emeritus Dean Orrin K. McMurray (seventy) returned to the classroom at Hastings, where he had taught as a novice, in 1902-04. Two years after being dropped from the Stanford Law Faculty (officially, "retired"), Professor Arthur M. Cathcart resumed his distinguished career in the fields of Torts and Constitutional Law.

Then came World War II, with young men even scarcer than before, and with it, replacing Dean McMurray, came Edward S. Thurston (sixty-seven), for whom there had been no room at Harvard Law School when he attained the age of statutory senility, in 1942. There matters rested until 1946, when the law school world was turned upside down.

On V-E Day, in 1945, the Hastings student body had numbered thirty-seven; in August, 1946, attendance soared to 483. More professors were needed and young men with teaching experience were all but impossible to find. The lesson of 1940 had not been forgotten. Hastings offered teaching positions to two more victims of compulsory retirement: Oliver L. McCaskill (sixty-eight), of the University of Illinois, and Chester G. Vernier (sixty-five), of Stanford University.

One year later, in the wake of 583 war veterans, came Professor Augustin Derby (sixty-five), of New York University, and within two academic years thereafter Ernest G. Lorenzen (seventy), of Yale University, Dudley O. McGovney (seventy-one), and Max Radin (sixty-eight), of the University of California School of Law (Berkeley), and Emeritus Deans Everett Fraser (seventy), of the University of Minnesota, and William G. Hale (sixty-eight), of the University of Southern California, and George G. Bogert (sixty-five), of the University of Chicago.

In 1948, Professor Lawrence Vold (sixty-two), of the University of Nebraska, who was not yet eligible for the "65 Club," became a member of the Faculty, as a "Pledge." He has had no successor.

We have added other distinguished names to the roster during the past twelve years. The great University of Michigan Law School has contributed four: Professors Lewis M. Simes, John B. Waite, Ralph W. Aigler and Edwin D. Dickinson.

The full-time faculty of 1959-60 consists of a registrar (forty-eight) and fifteen senior professors, whose ages range from sixty-five and one-half to eighty-four and average seventy-two and one-half. Professors in their late fifties and early sixties are turned away as "under age." A new form of discrimination!

During its first twenty years, the "65 Club" has had thirty members, exactly half of whom are active at the present time. They will be more numerous in the 1960's, when the College which they serve will be turning students away for lack of space.

It is self-evident that California's first Chief Justice did much more for Hastings in 1878 than to endow the College with $100,000. He left its board of directors free to employ teachers of law at any age, and to keep them as long as their services are needed.

So much for our "research" project. We hope that the findings will be accepted as an important contribution to the science of gerontology.

Golden Weddings Increase

According to the Health Information Foundation, about 150,000 couples each year celebrate a Golden Wedding Anniversary. Due to increases in life duration, a groom aged twenty-one and a bride aged seventeen now have forty-two chances in one hundred of living together for fifty years (barring divorce!).

Aging in a High Energy Society

Wilma Donahue, Ph.D.
Ann Arbor, Michigan

A POSITIVE and dynamic attitude toward aging is replacing the older concept of aging as a period of decline, poor health and unhappiness. The change in emphasis is brought about because the great majority of all who are alive today can expect to live through the highly productive years and to enjoy a period of retirement activity with a reasonable income. The added years of life are becoming healthier and more vigorous. Improved nutrition, easier homemaking and working conditions, a better health environment, new discoveries and procedures in medicine and rehabilitation are having a measurable impact.

Recently, the Surgeon General of the U. S. Public Health Service was able to report from the National Health Survey that 43 per cent of the people sixty-five years of age and over have no illness or impairment which interferes with the pursuit of their normal activities. Another 40 per cent report conditions which interfere only slightly or moderately. Only 17 per cent, one in six, are so severely disabled as to require assistance in living. These are encouraging figures. While they leave much to be desired, they suggest that the means to improve them lies within our group.

Of greatest importance is the improved income status of the aged because there is considerable evidence pointing to the association between economic status and health. Over the past decade, the proportion of older people with no income from employment or a public maintenance program decreased from three in ten to less than one in ten. While the proportion is heavily weighted with those which include an employed member, one-half of the families in which the head is sixty-five years of age or over and nearly one-half of the unattached older persons have incomes sufficient to meet basic needs, except for the costs of catastrophic illness.

More than a million retirees are drawing pensions from private industry, nearly two-thirds of the older male family heads own their own homes, and personal savings and privately held insurance and annuities are increasing. While we clearly have a long way to go in achieving economic security in the later years, we can see a brighter road ahead of us.

Beyond the extension of life itself, the outstanding achievement, as I see it, lies in the increasing opportunity to live independently in the later years and to devote more time to the pursuit of activities of one's own choosing.

Shortening the hours of work and increased life expectancy alone have given us 45,000 hours or twenty-two years of additional free time over the past century. Completion of parental responsibility between ages forty-five and fifty-five years and retirement from work between ages sixty and seventy add a great many more. It is significant that independence and free time come when maturity, growing out of accumulated experience and wisdom, and the potentials for full self-development and for broader social usefulness are greater than in any other period of life.

Making the most of maturity is a matter of individual choice and development: hence, it will always be basically the responsibility of the individual himself. Yet older people, like all people, need to find a climate of opportunity within which they can satisfy their requirements and aspirations. Modern technology has provided the productivity and manpower to produce the income, goods and services, and free time essential to meaningful maturity. The continuous expansion and growth of productivity through the high energy technology of the present has created a situation of abundance. We have had a more than six-fold increase in total gross national product and

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an almost three-fold increase in per capita gross national product in the period 1900 to 1957. Projections to 1970 indicate marked further rises based on increased productivity.

Whether our national output of goods and services increases at 3 per cent, 4 per cent, or 5 per cent in the future, the rate is considerably faster than the rate of increase in the population itself. This means continually rising income will be available for individual purchases of goods and services, for storing up retirement income credits, and for community expenditures for health, welfare, educational, and recreational programs.

Another factor, even more frequently overlooked in estimating the ability of society to support a large number of older persons is the effect of rising life expectancy on the length of work life, hence on the availability of manpower. The work life of the average male has been extended by ten years since the turn of the century. This 30 per cent increase in the length of working life has been achieved despite the postponement of entry into the work force and lengthening of the period of retirement. It also offsets the reduction in the length of the work week. We are, in fact, contributing approximately the same number of hours to the work force over our working lifetimes as our parents did when they worked a six-day, sixty-hour week. There is every prospect that this trend will continue. Life expectancy at birth, at ages twenty, thirty, and so on will continue to rise, with more and more of us living through the period of greatest economic productivity in the life cycle.

Still another consideration is the decline in the proportion of children and young people, plus the extension of life through the middle years, which have more than offset the increase in the elderly. Today, there are about eighty-five persons under twenty years of age and over sixty-five years of age in our population for each 100 between the ages of twenty and sixty-five years. This represents a decline from 94 per 100 in 1900. Forecasts for the remainder of the century indicate the ratio of the so-called dependency groups to those in the middle years will remain constant if it does not actually fall. Certainly, there is no indication that the rising number of old people is going to swamp the economy.

One final point is related to the effects of automation on our national economy and hence, on our ability to support the old. Opposing arguments are put forth with considerable vehemence. On the one hand, automation is said to decrease work opportunities. On the other hand, it is claimed that automation increases the number of jobs. Actually, over the past half century it has done both. It has enormously increased output and, hence, our purchasing power so that we are all able to enjoy a rising amount of goods and services (which creates more jobs) and, at the same time, it has greatly reduced the length of the work week and has given us retirement as a part of our way of life.

For all of these reasons, it appears that we are justified in assuming a continuing rise in the incomes of older people and the availability in our economy of the wherewithal to develop the programs and services which will give our older people a favorable climate of living. There can therefore be expected a continuing improvement in attitudes toward retirement and leisure because the older people will be reassured of their welcome place in society. When this is true, concern about working until infirm will be dissipated. In the past, a job has been a means and not an end. The current generation of Americans is developing new attitudes toward leisure as a desirable value and a crucial change which will determine the extent to which a new orientation to life in retirement will be developed—a necessity to the positive and healthful approach to aging.

Problems of All

Frederick C. Swartz, M.D., Lansing, chairman of AMA's Committee on Aging, stresses that in considering problems of the aged, it should be remembered the problems are those of individuals.

"We are at the point," he said, "where there are no problems, except those fostered by retirement, that are not the problems of both the over 65 age group and other age groups. And there is no uniform list of needs or wants of any age group."

Medical Manpower in Michigan

Supply of Physicians and Type of Practice

S. J. Axelrod, M.D.
W. R. Mills, Ph.D.
Ann Arbor, Michigan

STUDIES of medical manpower in Michigan were undertaken for the Committee on Medical Education Needs in Michigan as part of its charge "to develop specific recommendations on the next steps to be taken to meet the expected needs of medical education in the State of Michigan."[3] This report deals with the supply of physicians in Michigan and the nature of their practice. A previous report analyzed the distribution of physicians in Michigan with reference to rural-urban differences.[2]

Supply of Physicians

Physician-Population Ratio.—The most commonly used measure of the supply of physicians, the physician-population ratio, is the number of physicians relative to the population they serve. This ratio, obtained for a given area, is usually compared with a "standard" such as the physician-population ratio of another state, a group of states, or the United States as a whole.

The *American Medical Directory* is the best source for the number of physicians in each state. In the preparation of this report, the 1950, 1956 and 1958 editions were used. The listings of physicians are for the middle of the year preceding the year of publication.

From 1920 to 1957, the number of physicians in Michigan increased from 4,593 to 8,118 as shown in Table I. During the same period the state's population increased at a greater rate and the physician-population ratio decreased from 125 per 100,000 in 1920 to 104 in 1957.

Figure 1 shows that since 1920 Michigan has had fewer physicians relative to population than the East North Central states (Ohio, Indiana, Michigan, Illinois and Wisconsin) and the United States as a whole. From 1920 to 1939, the East North Central states, as well as Michigan, maintained their positions relative to the United States as a whole. Since 1939, the physician-population ratio of the United States has remained about the same, with 134 physicians per 100,000 population in 1939, and 133 physicians per 100,000 in 1957. Both the East North Central states and Michigan, however, show a rather sharp decline since 1939. Michigan's population is increasing more rapidly than that of the United States and the East North Central states, and the increase in the number of physicians in Michigan has not kept pace, as shown in Figure 2.

TABLE I. NUMBER OF PHYSICIANS, POPULATION AND PHYSICIAN-POPULATION RATIO, MICHIGAN, SELECTED YEARS, 1920-1957

Year	Number of Physicians	Population In Thousands	Physicians Per 100,000 Population
1920	4,593	3,668	125
1930	5,589	4,842	115
1939	6,362	5,156	123
1949	6,937	6,332	110
1955	7,900	7,358	107
1957	8,118	7,803	104

Source: American Medical Directory, 1958; Statistical Abstracts, 1958.

When the states are ranked according to the number of physicians per 100,000 population in 1957, about half the states have a higher ratio than Michigan, as shown in Table II. Michigan's relatively low rank is somewhat unexpected since wealthy industrialized states like Michigan are among the states better supplied with physicians.

There are limitations to the physician-population ratio as a measure of the supply of physicians. Both the age distribution of the physicians in a state and the proportion of the physicians who are available for care of the sick influence the effectiveness of the total supply of physicians. In those states with a high concentration of osteopaths, the services they provide should be considered in evaluating the total supply of medical manpower. With regard to the population served, its age and sex composition obviously influences the need for physicians' care. Older people and women in the child-bearing ages need more medical care than other age-sex groups. If a state differs

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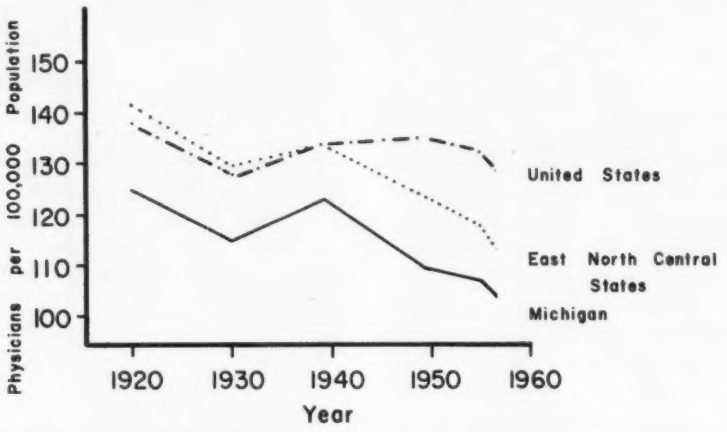
markedly in the age-sex composition of its population from that of the United States as a whole, this difference should be taken into account. However, states with fewer older people generally have a higher proportion of women in the child-bearing ages. These two population characteristics tend to neutralize each other in influencing the need for medical care. For this reason, the age-sex composition of the population is usually ignored in computing physician-population ratios. For more precise comparisons between states, it is necessary to make adjustments for differences in the age-sex composition of their populations.

In order to determine the effect of the above-mentioned factors on Michigan's rank among the states in the ratio of physicians to population, adjustments were made for the age distribution of physicians and for the age-sex characteristics of the population for each of the states for 1950. The United States as a whole was used as a standard. Both Michigan's physicians and her population are relatively young, the former indicating greater effectiveness per physician; the latter, less need. These adjusted physician-population ratios improve Michigan's rank among the states somewhat. Further adjustments in the physician-population ratios of the states were made by taking into account the proportion of physicians available for care of the sick (physicians in "active private practice," interns and residents and physicians in "other full-time hospital services") and the number of osteopaths in the state. The net effect of all these adjustments is to improve Michigan's rank, placing the state somewhere between fifteenth and twentieth among the states according to physician-population ratios for 1957.*

Michigan is in the middle third of the states according to this adjusted physician-population ratio. Compared with the fifteen or twenty states with higher adjusted physician-population ratios, Michigan's need for



Note: The decline in the ratio in the 1955–1957 period is completely due to a change in the classification system in the case of the United States and is primarily due to a classification change in the case of the other states.

Fig. 1. Number of physicians per 100,000 population, United States, East North Central States, and Michigan during selected years, 1920-1957. Source: American Medical Directory, 1958; Statistical Abstracts, 1958.

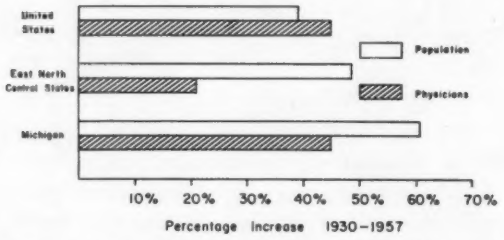


Fig. 2. Percentage increase in number of physicians and population, United States, East North Central States, and Michigan during selected years 1930-1957. Source: American Medical Directory, 1958; Statistical Abstracts, 1958.

*Adjustments for age differences among physicians and the age-sex composition of the population were based on 1950 data. Adjustments for proportion of physicians available for care of the sick and for the number of osteopaths were based on 1955 data. Since all the above data are not available for 1957 and since all four factors were not adjusted for simultaneously, only an approximate adjusted rank can be assigned for 1957.

TABLE II. RANK OF STATES BY NUMBER OF PHYSICIANS PER 100,000 POPULATION, 1957

Rank	State	Number of Physicians	Population In Thousands	Physicians Per 100,000 Population
1	New York	30,786	15,888	194
2	Massachusetts	8,701	4,866	179
3	Connecticut	3,906	2,252	173
4	California	21,803	13,922	157
5	Vermont	550	376	146
6	Colorado	2,390	1,673	141
7	New Hampshire	771	572	135
8	Maryland	3,824	2,895	132
9	Pennsylvania	14,507	11,043	131
10	Minnesota	4,281	3,321	129
11	Illinois	12,211	9,637	127
12	New Jersey	6,825	5,627	121
13	Oregon	2,142	1,769	121
14	Utah	1,026	851	121
15	Rhode Island	1,035	862	120
16	Washington	3,269	2,722	120
17	Florida	4,912	4,098	120
18	Ohio	10,986	9,200	119
19	Delaware	514	438	117
20	Missouri	4,752	4,255	112
21	Louisiana	3,387	3,068	110
22	Nebraska	1,515	1,452	104
23	MICHIGAN	8,118	7,803	104
24	Maine	978	943	104
25	Kansas	2,199	2,136	103
26	Wisconsin	3,920	3,862	102
27	Tennessee	3,466	3,463	100
28	Iowa	2,715	2,799	99
29	Virginia	3,677	3,797	97
30	Indiana	4,364	4,533	96
31	Texas	8,770	9,138	96
32	Nevada	255	267	95
33	Arizona	1,075	1,136	95
34	Montana	629	666	94
35	Oklahoma	2,143	2,277	94
36	North Carolina	3,991	4,498	89
37	Idaho	364	640	88
38	Georgia	3,320	3,779	88
39	Arkansas	1,550	1,768	88
40	Kentucky	2,581	3,040	85
41	West Virginia	1,671	1,976	85
42	Wyoming	256	316	81
43	New Mexico	647	830	78
44	North Dakota	483	644	75
45	Alabama	2,344	3,151	74
46	South Carolina	1,735	2,370	73
47	Mississippi	1,576	2,185	72
48	South Dakota	490	702	70
	United States	226,625	170,337	133*

Source: American Medical Directory, 1958; Statistical Abstracts, 1958.

*Excluding those physicians on active duty with the reserve corps of the Army, Navy and Air Force (such physicians are excluded from the state totals presented in this table) decreases the ratio for the United States from 133 to 129.

additional physicians is clear. If Michigan's physician-population ratio continues to decrease as it has over the past twenty years, this need will become even greater.

Need and Effective Economic Demand.—The physician-population ratio is a measure of the supply of physicians relative to need. A distinction is commonly made between the *need* for physicians resulting from the amount of illness in the population, and the effective economic *demand* for physicians' services resulting from the willingness and ability of the population to purchase physicians' services. The effective economic demand for physicians' services can be measured by the amount of money spent for physicians' services. The greater the expenditure for physicians' services, the greater the demand. The number of physicians represents the available potential for meeting this demand. In a given area, the amount of money spent for physicians' services divided by the number of physicians gives the average gross income of the physicians. This figure, which represents the relationship between the demand for physicians' services and the supply of physicians, measures the degree to which the effective economic demand for physicians' services is being met. States whose physicians have lower incomes on the average are the states best supplied with physicians relative to the effective economic demand for their services. On the other hand, states whose physicians have higher incomes on the average are the ones most poorly supplied with physicians relative to demand. To illustrate this point, Alabama, a state whose physicians have relatively high average incomes, is poorly supplied with physicians relative to demand. New York, where physicians' incomes are relatively low, is well supplied with physicians relative to demand. Michigan's physicians have incomes which are among the highest in the nation. Michigan is therefore a state which is poorly supplied with physicians relative to demand. According to the best available information on physicians' incomes, over two-thirds of the states are better supplied with physicians than Michigan when the supply of physicians is compared with effective economic demand.[4]

Gains and Losses in the Number of Physicians, 1949-1955.—From 1949 to 1955, the number of physicians in Michigan increased by 963, from 6,937 to 7,900, an increase of 14 per cent.** By comparing the listing of Michigan physicians in the 1950 and 1956 editions of the *American Medical Directory* it is possible to learn something about the characteristics of those physicians who entered practice in Michigan and those physicians who left. While there was a net gain of 963 in the total number of physicians over this six-year period, the net gain is reduced to 805 when only practicing physicians are considered.† Table III shows the nature of the gains and losses in the number of practicing physicians in Michigan in the six-year period 1949 to 1955. In this same period, 1,073 physicians graduated from the two Michigan medical schools. Of

**In this same six-year period the number of osteopaths increased from 909 to 1,261, an increase of 39 per cent. According to the 1959 American Osteopathic Association Yearbook and Directory of Osteopathic Physicians, there were 1,484 osteopaths in Michigan in 1958.

†"Practicing physicians" are those physicians in active private practice plus physicians with a hospital address (interns and residents and those in full-time hospital services).

TABLE III. GAINS AND LOSSES IN NUMBER OF PRACTICING PHYSICIANS IN MICHIGAN, 1949-1955

Replacements by graduates of Michigan medical schools	
Graduates of Michigan medical schools, 1949-1954	659
Losses through retirement and death	765
Net loss	−106
Migration by physicians in practice in 1949	
Into Michigan	587
Out of Michigan	816
Net loss	−229
Replacements by graduates of non-Michigan medical schools, 1949-1954	1,140
Total gains	1,140
Total losses	335
Net gain	805

Source: Special tabulation, American Medical Directories, 1950 and 1956.

these, 659 of them were practicing in Michigan in 1955. This number was exceeded by the number of physicians who retired or died, resulting in a net loss of 106 (Table III). It is probable that some of the 1949-1954 graduates in training outside of Michigan will subsequently return to Michigan. Nevertheless, the state's two medical schools are not providing a sufficient supply of physicians to take care of the losses through retirement and death and the increased need due to the state's expanding population.

Considering physicians who already were in practice in 1949, we find an excess of out-migrants with a net loss of 229. Further analysis of the physicians who migrated indicates that about half the out-migrants left the state at the completion of their internships and residency training programs. In view of this, Michigan should be regarded as an important training center for physicians from other states rather than an unattractive place to practice. From 1949 to 1955, 1,140 graduates of non-Michigan medical schools entered the state, many of them for internships and residencies. This group far exceeded the losses during the six-year period and produced a net gain of 805 practicing physicians. It is clear that much of the movement of physicians into and out of Michigan is accounted for by interns and residents. As the hospital becomes more central in the practice of medicine, this group of physicians represents an increasingly important segment of the medical manpower resources of the state.

Type of Practice

In Michigan, the proportion of physicians who are in active private practice has decreased from 85 per cent in 1930 to 66 per cent in 1957, as shown in Table IV.†† This decline should not be interpreted to mean that a smaller proportion of Michigan's physicians are available to care for the sick. The decline in the proportion of active private practice physicians has been balanced by an increase in the number of physicians whose practice is confined to the hospital, that is, interns, residents, physicians in full-time hospital service. This group increased from 12 per cent of all of Michigan's physicians in 1937 to 26 per cent in 1957. As a result, about the same proportion of Michigan's physicians are available to care for the sick, but now more of these physicians' services are being provided in the hospital.

TABLE IV. NUMBER OF PHYSICIANS IN MICHIGAN, BY ACTIVE PRIVATE PRACTICE STATUS, SELECTED YEARS, 1930-1957

Year	In Active Private Practice		Not In Active Private Practice						Total Physicians	
			Interns, Residents, Full-Time Hospital Staff		Administration, Teaching, Research, Retired, "Not In Practice"		Total			
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
1930	4,725	84.5	*	*	*	*	860	15.5	5,585	100.0
1937	4,958	80.7	722	11.8	462	7.5	1,184	19.3	6,142	100.0
1949	5,343	77.0	1,172	16.9	422	6.1	1,594	23.0	6,937	100.0
1955	5,168	65.4	2,063	26.1	669	8.5	2,732	34.6	7,900	100.0
1957	5,384	65.8	2,119	25.9	675	8.2	2,794	34.2	8,178	100.0

*Information not available.

Source: American Medical Directories, 1950, 1956, 1958; Number of Physicians in the United States by County, July 1, 1938, Directory Department, American Medical Association; Report of the Committee on Survey of Medical Service and Health Agencies, Michigan State Medical Society, 1933.

The increase in the number of physicians in hospitals has been due to the greater use of hospitals in the care of the sick and in the training of specialists. As shown in Table V, there has been a marked increase in the number of internships and residency training programs in recent years. While the number of physicians in full-time hospital service, other than interns and residents, almost doubled between 1937

††The term "active private practice" as used by the *American Medical Directory*, means physicians other than interns and residents, physicians in full-time hospital service, physicians in teaching, research, and administration, retired physicians and "others not in practice."

and 1957, the number of interns and residents increased almost four-fold. Michigan has a very extensive internship and residency training program. Only one state, Louisiana, had a higher proportion of physicians who were interns and residents in 1957.[1]

Studies of the type of practice of physicians are generally based on information contained in the *American Medical Directory*. The information given under the listing of each physician is not always complete enough for a precise classification of his type of practice. In this report, a classification system is used which recognizes the limitations of the Directory data. This classification system separates physicians providing care for the general population into two groups, those with an office address outside the hospital and those with a hospital address (Table VI). The use of an objective criterion, office address, reduces inconsistencies in classifying physicians over several time periods. All physicians in Michigan listed in the 1949 and the 1955 editions of the *American Medical Directory* were classified by the scheme (Table VI).

TABLE V. NUMBER OF PHYSICIANS IN MICHIGAN IN FULL-TIME HOSPITAL SERVICE, BY TRAINING STATUS, 1937, 1955 AND 1957

Year	Interns and Residents	Full-Time Hospital Staff	Total
1937	414	308	722
1955	1,451	612	2,063
1957	1,548	571	2,119

Source: 1937: Number of Physicians in the United States by County, July 1, 1938, Directory Department of the American Medical Association.
1955: American Medical Directory, 1956.
1957: American Medical Directory, 1958.

TABLE VI. PHYSICIANS IN MICHIGAN, BY AVAILABILITY FOR PROVIDING CARE, 1949 AND 1955

Type of Practice	1949		1955	
	Number	Per Cent	Number	Per Cent
Available for care of general population	6,355	91.6	7,171	90.8
Active private practice, office not in a hospital	4,973	71.7	5,226	66.2
Hospital address	1,382	19.9	1,945	24.6
Active private practice and salaried physicians	385	5.5	539	6.9
Interns	220	3.2	390	4.9
Residents	777	11.2	1,016	12.9
Available for care of special beneficiaries only	55	0.8	62	0.8
Federal government hospitals	52	0.7	55	0.7
College health service	3	—	7	0.1
Not providing care	530	7.6	664	8.4
Teaching and research	117	1.7	176	2.1
Administration	164	2.4	181	2.3
Retired	160	2.3	204	2.6
All others not in practice	89	1.3	103	1.3
Grand total	6,940	100.0	7,897	100.0

Source: Special tabulations from American Medical Directories, 1950 and 1956.

The only major shift which has taken place in the work setting of Michigan's physicians from 1949 to 1955 has been within the group of physicians providing care for the general population. Physicians in active private practice with offices outside the hospital decreased from 72 per cent of all physicians in 1949 to 66 per cent in 1955. During this same period, physicians with a hospital address increased from 20 per cent of all physicians in 1949 to 25 per cent in 1955. This increase was shared by all types of physicians with hospital addresses. Despite the tremendous expansion of medical research activities and the growing need for physicians in teaching and administrative positions, there has been virtually no increase in the proportion of physicians devoting themselves to these careers.

It has been suggested that an increasing proportion of physicians providing day-to-day care for the general population receives its income as salary. Except for interns and residents, there is insufficient information in the *American Medical Directory* to confirm this. However, it is known that some physicians listed as being in active private practice are employed by other physicians on a salaried basis, and not all physicians with a hospital address are salaried.

Specialization.—Specialization is viewed by some as creating problems by increasing the costs of medical care, exaggerating the rural-urban maldistribution of physicians and introducing difficulties in patient-physician and physician-physician relations. Others regard specialization as a necessary condition for advancing the science of medicine and improving the quality of medical care. Regardless of the value judgments which may be made concerning the impact of specialization on medical practice, there is an unmistakable trend toward greater specialization in medicine.

Michigan's physicians show this trend. The proportion of physicians in active private practice in Michigan who designate themselves full-time specialists increased from 16 per cent in 1930 to 48 per cent in 1957 (Table VII). During this same period, the proportion of general practitioners decreased from 64 per cent to 35 per cent, while the proportion of "partial specialists" changed very little.

TABLE VII. NUMBER OF PHYSICIANS IN MICHIGAN IN ACTIVE PRIVATE PRACTICE, BY SPECIALIZATION STATUS, SELECTED YEARS, 1930-1957

Year	Specialization Status						Total Active Private Practice	
	Full-Time Specialists		General Practice		Part-Time Specialists			
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
1930	770	16.3	3,040	64.4	907	19.3	4,717	100.0
1949	2,106	39.4	2,380	44.5	856	16.0	5,343	100.0
1955	2,296	44.4	2,082	40.3	790	15.3	5,168	100.0
1957	2,599	48.3	1,906	35.4	879	16.3	5,384	100.0

Source: 1930: Report of the Committee on Survey of Medical Services and Health Agencies, Michigan State Medical Society, 1933.
1949: American Medical Directory, 1950.
1955: American Medical Directory, 1956.
1957: American Medical Directory, 1958.

TABLE VIII. DIPLOMATES OF AMERICAN SPECIALTY BOARDS IN MICHIGAN, 1957

American Specialty Board	Number	Per Cent
Internal medicine	289	14.4
Surgery	282	14.1
Pediatrics	209	10.4
Obstetrics and gynecology	187	9.3
Radiology	174	8.7
Psychiatry and neurology	171	8.5
Ophthalmology	138	6.9
Otolaryngology	123	6.1
Pathology	85	4.2
Orthopaedic surgery	76	3.8
Urology	60	3.0
Dermatology	51	2.5
Anesthesiology	40	2.0
Preventive medicine	37	1.8
Neurological surgery	23	1.1
Thoracic surgery	23	1.1
Plastic surgery	13	.6
Proctology	12	.6
Physical medicine and rehabilitation	8	.4
Total	2,001	99.5

Source: American Medical Directory, 1958.

Physicians designating themselves "partial specialists" are often classified with general practitioners. Some have questioned whether the partial specialist should not more appropriately be regarded as a physician moving toward full-time specialty practice. When general practitioners in Michigan in 1949 were compared with the partial specialists, it was found that the general practitioners were more likely to have become full-time specialists by 1955. Apparently the partial specialist does not progress to full-time specialty status more frequently than does the general practitioner.

The use of American Specialty Boards as certifying bodies has served to formalize the designation of specialists and has substituted objective criteria for self-designation in determining specialty status. The proportion of full-time specialists in Michigan who are certified by American Specialty Boards has increased from 45 per cent in 1949 to 60 per cent in 1957. If this trend continues, certification by an American Specialty Board will soon define the full-time specialist.

Table VIII shows that of the 2001 Board-certified specialists in Michigan in 1957, almost half are in four fields of specialization: Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology. The smallest number is found in Physical Medicine and Rehabilitation with only eight physicians with their Boards. Each of the nineteen American Specialty Boards is represented.

The proportion of full-time specialists with Board certification varies among the several specialties. In 1957, almost all radiologists in Michigan, 98 per cent, were certified by their American Board. Eighty-eight per cent of all Michigan's neurosurgeons and 86 per cent of the thoracic surgeons were certified. By way of contrast, only 46 per cent of the full-time specialist internists were certified by the American Board of Internal Medicine, and only 54 per cent of the full-time specialist surgeons and the obstetricians-gynecologists were certified by their Boards. It may be that the fields of specialization which involve the most highly technical skills, for example, radiology and neurologic surgery, are more likely to require a formal system of designating professional competence.

Summary

This report of the supply of physicians in Michigan and the nature of their practice may be summarized as follows:

1. From 1920 to 1957, the number of physicians

(Continued on Page 792)

Hematuria: Comparison of Chemical with Microscopic Examination

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RAPID TABLET test methods have been introduced recently for the detection of occult blood in urine and other body fluids. These tests are simple and designed for use in the small clinical laboratory as well as the larger hospital department. The tablet tests are especially useful for detection of hematuria in patients receiving anticoagulant therapy.[1]

Caplan and Descombe[2] found that the 0-tolidine test, such as the Occultest* will detect 5 x 10^4 cells per milliliter, equivalent to 0.15 mg. of hemoglobin per 100 milliliters of urine. Routine microscopic examination of a centrifuged deposit will detect between 10^3 and 10^4 cells per milliliter, according to the details of the technique. Other workers, using urine specimens to which blood was added in the laboratory, have also attested to the value of the chemical test.[3,4,5]

This report describes the results of studies in the Department of Pathology at Hurley Hospital in which the accuracy of the rapid tablet test (Occultest) was compared to microscopic study of routine urine specimens for the presence of erythrocytes. In addition, particular attention was paid to the possible effect of the presence of large numbers of leukocytes on the tablet test results.

Method

Two thousand seven hundred random urine specimens up to twelve hours old from newly admitted and in-patients were checked independently of the microscopic examinations for the presence of varying amounts of blood by a rapid tablet test according to accompanying instructions.

Rapid Tablet Test

The Occultest tablet reagent method is based on the property of the peroxidase-like activity of the blood cells to reduce peroxide and liberate oxygen. The oxygen is detected in an acid medium by orthotolidine. Orthotolidine and strontium peroxide are compressed with tartaric acid and calcium acetate into a tablet. Oxygen liberated from strontium peroxide when reduced by peroxidase is detected by the orthotolidine; the tartaric acid and calcium acetate supply the necessary acidity.

Tablet Technique

One drop of urine was placed on a piece of filter paper. A test tablet was placed in the center of the moist area and two drops of water were placed on the tablet so that they would run down onto the paper. If a significant amount of blood was present, a distinct blue area formed within two minutes on the paper surrounding the tablet; if negative, the paper did not change color even though the tablet turned slightly bluish. Only the discoloration of the filter paper was considered of significance.

Microscopic Examination of Urine Sediment

Approximately 5.0 milliliters of well-mixed urine was transferred from the specimen to a 7.0 milliliter test tube and centrifuged at 300 RPM for five minutes. The supernatant was equally divided and poured into two test tubes for the Exton's sulfosalicylic acid reaction. This left approximately 0.5 to 1.0 milliliters of urinary sediment and supernatant fluid in the bottom of the tube. The sediment was examined immediately by inverting and tapping the test tube over a clean glass microscopic slide and covered by a 22 x 22 mm. plastic coverslip. The urinary sediment was scanned by the low power objective of the microscope with a magnification of 100 x. In this manner it was determined if the elements of the sediment were evenly dispersed beneath the coverslip. Erythrocytes and leukocytes were then counted in 10 fields under

TABLE I.

Microscopic Examination	Occultest			
	Negative	Small	Moderate	Large
Negative	1752	57	12	2
Rare	443	55	18	1
0- 5 Erythrocytes/HPF	80	71	26	0
5-10 Erythrocytes/HPF	9	16	23	9
10-25 Erythrocytes/HPF	3	19	16	6
25-50 Erythrocytes/HPF	0	2	2	8
Innumerable	2	2	5	61

From the Department of Pathology, Hurley Hospital, Flint, Michigan.

Supported in part by a grant from the Ames Co., Elkhart, Indiana.

*Occultest is a trademark of the Ames Co., Elkhart, Indiana.

the high dry power objective with a magnification of 430 x, and the average number of cells was recorded.

Each urine was then placed in one of the following categories:

1. Negative	No erythrocytes seen in 10 HPF
2. Rare	Only 1 erythrocyte in 3 or 4 or less of 10 HPF
3. 0-5	0 to 5 erythrocytes in nearly each of 10 HPF
4. 5-10	5 to 10 erythrocytes in each of 10 HPF
5. 10-25	10 to 25 erythrocytes in each of 10 HPF
6. 25-50	25 to 50 erythrocytes in each of 10 HPF
7. 50-75	50 to 75 erythrocytes in each of 10 HPF
8. Innumerable	More than 75 erythrocytes in each of 10 HPF

Microscopic and chemical testing were performed independently and without knowledge of the results on corresponding samples. All microscopic examinations were performed by a resident in clinical pathology (G.M.L.).

Results

Of the 2,700 specimens examined, 948 showed the presence of varying amounts of blood with the Occultest, on microscopic study, or by both methods. This figure (35.1 per cent) was a rather high proportion of the total and was partially attributable to receipt of many uncatheterized specimens from females and many specimens from the obstetrical service. These results are summarized in Table I.

The number of leukocytes seen on microscopic examination was also compared to Occultest results, and Table II shows these results.

A positive Occultest in the presence of small or large numbers of leukocytes was in all instances accompanied by microscopic evidence of erythrocytes.

Discussion

It is apparent from Table I that the rapid tablet test and the microscopic findings correlate very closely. In urines which gave small and moderately positive tests to Occultest and showed no or rare erythrocytes on microscopic examination, it seems quite probable that here we were dealing with samples which had been voided for some time and that hemolysis of the erythrocytes had occurred. If this were the case, the positive tests could be attributed to free hemoglobin present in the urine specimens. The two specimens which showed a large positive test by the rapid tablet test yet were negative by microscopic examination might possibly be explained by hemolysis but more likely represent laboratory errors.

TABLE II.

Occultest Results	Leukocytes Per High Power Field					
	0	Rare	1-9	11-20	25-50	Innumerable
Small—slight positive	46	35	76	18	22	10
Moderately positive	23	16	28	10	14	8
Large positive	7	3	10	7	8	30
Negative	0	589	465	104	66	11

For uniform and correct results, it is imperative to read the test exactly two minutes after the addition of two drops of water to the tablet as the final step in the procedure.

It is also apparent from Table I that a rare erythrocyte seen on microscopic study may not, and probably will not, give a positive tablet test. When 0 to 10 erythrocytes are seen per high power field, the tablet test results are somewhat variable but for the most part give satisfactory correlation, particularly if more than five cells are seen per high power field. While the chemical test therefore is a satisfactory screening test for occult blood, a positive result is an indication for microscopic examination.

Table II shows no apparent relationship between positive tablet tests for occult blood and the presence of leukocytes in the specimens.

Summary

A simple, rapid tablet test (Occultest) for the detection of occult blood in urine and other body fluids has been compared with microscopic study of centrifuged urine sediment. The test is accurate, with a sensitivity comparable to the average standard microscopic study of urine sediment for erythrocytes. The test is simple to perform, but for satisfactory results it must be read at precisely two minutes after the final step in the procedure. The presence of small to innumerable leukocytes in the specimen does not influence the test results. The test should not be considered a substitute for careful microscopic examination but is valuable in the detection of occult blood, particularly in the frequent instances where hemolysis has occurred.

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Aging Is Part of Life

Aging always has been such a natural and inevitable part of life for all human beings that few persons have paid particular attention to it as a process or to the aging persons as having unique problems until recent times.

Illness always has been slightly more prevalent among older persons but physicians have undertaken to look after such individuals when they were ill regardless of their age and without making an issue of aging. There are no diseases or circumstances peculiar to the aging alone. Anyone can be without health and strength or friends and finances at any age.

Since the advent of social service activities and the entry of what might be called political expediences into the field of social inquiry and planning there has been more concern about aging. Numerous "do-good" programs have arisen.

Perhaps it is a new area for exploitation. The aging citizens may have become such a large segment of the voting population that the politicians are beginning to notice them. The politicians are sensitive about there being occasional hardship cases and are quick to exploit them by proposing a governmental panacea to be administered to all when only a few are in need.

The idea that a person should retire from active work when he reaches sixty-five years of age and thereafter live in complete idleness is a great fallacy. Subsisting on pensions derived from funds provided by employers or the federal government may be a way of life but it does not have the historic sanction that work has and it is not in the best interests of the workmen.

Probably primitive man worked at the time of the chase and battle but did not work very hard during the intervals. Modern man has become adjusted to work and modern economics demand it of him.

The maintenance of independence generally requires an income producing occupation.

The person who retires to the "Life of Riley" and does nothing is soon disappointed and his remaining years are less satisfying.

Many retired individuals are compelled to undertake new or different work after being forced out of previous employment. The work often is more strenuous than that done with such familiarity before retirement. Generally there is substantially less remuneration for almost any employment secured after sixty-five years of age. The exceptions are noteworthy.

Every man with a well-developed social consciousness assumes some responsibility toward other persons and must lend his efforts in trying to develop a more mature attitude toward persons in their later years.

In reality, the problems attributed to aging have been overstated and the experience, skill and mature judgment of such persons have been undervalued.

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A great many old timers continue in good health and to function rather well far into later life. A majority of them manage their own affairs in a satisfactory manner or have them handled within their own families. A minority may develop certain problems of health and finances or how to make the most of their assets. Inflation tends to make this a little difficult at present.

Aging persons should have the privilege of thinking and acting for themselves for the majority of them are quite capable and may resent interference. The vital processes remaining after a lifetime of competition with environment and the surviving memories, habits, ideas and precepts make up a rich storehouse for old age.

There are various attitudes toward aging. Negative concepts are to be avoided. Aging persons should expect to maintain passable health and to avoid becoming wards of a paternalistic government in old age.

The road back from the welfare state to individual and family responsibility may be long and rough but it is the most satisfying and will make aging a respected and integrated part of life.

(Guest editorial by Charles W. Sellers, M.D., Member of MSMS Geriatrics Committee)

The Reading Public and Medicine

It has been noticed many times previously that the public will read avidly almost anything which is published in the lay press or the national magazines bearing upon the practice and problems of the medical profession.

Articles in several magazines the last few months have indicated an improved and increasingly accurate and valuable use of this type of publication, to build a good feeling of respect for the profession. The past ten or twenty years has produced a wonderful improvement.

Recently, another group of articles has come to our attention. An educator asked if it was true that hospitals have set up procedures which doctors are supposed to follow in caring for certain accident cases.

The reference was to a report in *Look* magazine for March 1, 1960 which carried a cover page title, "TV's Roger Smith, How He Survived His Doctor's Mistakes." The article was six profusely illustrated pages with the heading "Five Hours From Death" in half inch type. There was a glowing case history about an accident, about the patient's numerous trips in and out of hospitals, about tests made and tests not made, and with names of doctors who cared for the patient publicized and criticized.

Without considering the right or wrong of diagnosis, treatment, etc., the ending demands serious thought.

We quote two paragraphs in the summation:

"Negligence in the legal sense means carelessness or the failure to act as a reasonably prudent careful person would have acted under similar circumstances. Negligence for a doctor comes under the heading of malpractice."

"The patient had consulted his attorneys and has been advised that he has a cause or action of malpractice against the first three physicians who attended him. Only a court can decide that issue."

We were astounded that such an article would be published, naming names and discussing procedures, mentioning neglect. Our response to the educator who asked the question was that this would stimulate a malpractice suit, but the magazine risks suit for defamation of character. The doctors have brought suit against the magazine for $3,450,000 damages.

Attention having been called to *Look* magazine, we found that for four issues it has published articles involving the medical profession in one way or another. On February 1, *Look* carried a 21-page, illustrated article on "Psychiatry—The Troubled Science," discussing what they claim is disagreement among psychiatrists as to whether the patient needs pills, medication or psychoanalysis, whether mental disease may be treated with drugs, etc., or with long continued psychoanalysis. On March 15, an article "Where Does Your Charity Dollar Go?" described most of the methods for raising money for charitable and other purposes including medical programs, United Funds, Community Chests and others. This article was very critical of most of these programs including some centered in Michigan. The next article was in the March 29 issue—"Our New Hospital Crisis." This is a well-written research into the methods of securing interns and house physicians for our hospitals. There is a lack of sufficient medical graduates in America to fill vacancies and the attempt is to fill these vacancies with foreign graduates, some of whom are very poorly trained.

The growing feeling among hospital patients that prices are too high, that the insurance fees are increasing too fast should be explained and calmed, this article said. Hospital and medical care must be given the patient, and there aren't enough internes or enough M.D.'s being graduated to fill the vacant places in our hospitals.

Can there be good in this group of articles by presenting medical problems to the public in a style of writing so suggestive of "muckraking" of the era up to two decades ago? That method of communication outlived its usefulness but helped to produce a better America. We are not taking issue, we are calling attention to a new or renewed type of communication with many qualms in our thinking.

Anniversary

The month of March this year was an anniversary. Blue Shield made no special celebration or announcement. However, at the meeting of the Board on March 2, Gordon Goodrich invited attention to the fact that Michigan Medical Service was having a twentieth anniversary.

Michigan Medical Service was officially opened the first of March, 1940, in a small 20-foot square room with a desk and a clerk, ready for business. The first activity was a service contract to cover surgery in the hospital for the Ford Motor Company employes, 78,000 of them.

So far as anyone in Michigan knew, that was the first Blue Shield contract.

Development of the Michigan Medical Service had occupied the attention of the various MSMS committees over a period of years. A very active one under Ralph H. Pino, M.D., after several years of study, reached the point where expert insurance, economic and legal advice was essential and no progress being made. He turned the material and the problem back to the Executive Committee of the Council of the Michigan State Medical Society who worked on it for another two years. After various consultations a special enabling act was deemed necessary from the legislature and was sponsored by Mrs. Dora Stovkman, a member of the legislature representing the farm groups.

The Governor signed the enabling act on May 18, 1939. The MSMS Council then completed the development of detailed plans which were presented to the House of Delegates and approved September 18, 1939. The first Board of Directors was established November 30, 1939. The Board consisted of seventeen men, fourteen of whom were M.D.'s and three of whom were laymen, namely: Henry R. Carstens, Andrew S. Brunk, Burton R. Corbus, Howard H. Cummings, L. Fernald Foster, Wilfrid Haughey, Ralph H. Holmes, William A. Hyland, Henry A. Luce, Vernor M. Moore, Ralph H. Pino, Phil A. Riley, Oscar D. Stryker, and P. H. Urmston. The laymen were Wm. J. Burns, Executive Director of the Michigan State Medical Society; William J. Norton, Administrator of the Cousins Children's Fund; and Dora H. Stockman of the legislature who had sponsored and was responsible for passing our enabling act.

At that time in history, Michigan Medical Service and its sponsors did not know of any other organization providing pre-payment of medical services. Some years later we discovered that the California State Medical Society had preceded us by a few months. There were also several small county groups in Oregon and Washington.

Pioneers in Michigan Medical Service had consulted with the American Medical Association and been told that they could not do this "insurance" job. They had consulted with insurance advisors, begging them to start it, but were told that medical services were uninsurable.

The first contract sold covering the 78,000 Ford employes presented problems which had to be solved. The group was fortunate in some ways. They were actually pushed into accepting this contract. Ford Motor Company was making available $1 per month for each employe, and was negotiating with the Michigan Society for Group Hospitalization (the original name for Michigan Hospital Service). Ford would pay 60c a month for the hospital bill and 40c was available for Michigan Medical Service to guarantee a service. What this 40c would cover nobody knew. There were no actuarial figures for there was no experience. The medical officers agreed with the membership to take this contract and service it, pay our doctors as far as the money would go—prorating if necessary. That was the original participating certificate. This first contract paid out. There was no loss in it. Later experience was different.

On September 25, 1940, the Michigan Medical Service Board was increased to 25 members with the addition of Drs. Earl I. Carr, H. A. Haynes, W. H. Huron, and F. J. Sladen, and laymen George Burke, John Reid, Richard Frankensteen and Harry Taliaferro. John Reid at that time represented the American Federation of Labor and later was state Commissioner of Labor. Messrs. Frankensteen and Taliaferro represented the CIO.

On September 17, 1941, the Board was expanded to thirty-five, adding the following medical men: O. O. Beck, T. E. DeGurse, H. J. Kuhlman, P. L. Ledwidge, R. S. Morrish, R. L. Novy, and hospital representatives Robert Greve and Mrs. Kate Hard, and lay representatives E. H. Fletcher and Earl Finney. Mr. Fletcher was a Certified Public Accountant.

What's Public About Health?

Today's world is not geared to those who still retain a love of privacy. The picture window, the Vistadome train, the open-floor-plan office, the ubiquitous television lens, the man-on-the-street interview, the bedroom telephone—these are all a part of the public era. Today, it seems that almost everything is a matter of public concern, from public schools to public welfare, from public roads to public health.

What, in short, is public about health?

Although we have never been asked that question in exactly that way, it is not merely rhetorical. On occasion, a practicing physician has been known to ask something like it. Oh, he may be willing to concede that the presence of dangerous communicable diseases require some public control but beyond that he is usually reluctant to go. We do not mean to imply that most, or even a great many physicians hold to this opinion. But it would be foolish to deny that there are some who do, and often they are most articulate about it.

This is unfortunate because it can deprive people of a quality of health care that is possible but is not too often realized—the quality of health care which can result from the close working together of physician specialists in public health and private physicians.

For, the fact is that a boil and a backache, vomiting, and a cervical smear are matters of public health concern. The fact is that whatever distinctions there may have been between private medicine and public health are now largely academic. For both are involved in the prevention, diagnosis, and treatment of disease and the promotion of health. The woman with a boil must be treated by her physician certainly. But what about the responsibility to the public to see to it that staphyloccocal infections do not endanger all persons, especially mothers and infants, who are in our hospitals. Control of such infections is not a problem with which the private physician alone can effectively deal. It requires organized community action. It is a *public* health matter.

A backache? It might, of course, be simply muscular pain. On the other hand, it might be an early symptom of heart disease. The private physician must diagnose, treat, and even try to prevent heart disease. But what about the necessity for organized action to help get people in for a periodic health appraisal so that an early diagnosis can be made? What about the need to help the victim of a cardiovascular accident regain the use of his arms and legs and even his mind, so that he may become a useful human being again rather than a vegetable? What about the necessity of assuring good nursing homes that really care about their patients and help them to recover instead of merely storing them until they die? These are all problems associated with heart as well as other chronic diseases. Without organized public action and support the private physician is helpless to solve them. They are *public* health matters.

Vomiting? It might mean any number of things. But what if it is a result of exposure to toxic levels of any one of a number of substances in an automobile repair shop or an industrial plant? Is this a problem that can be handled by the traditional doctor-patient relationship? Or is it not instead a problem to be dealt with by public health officials in cooperation with plant management so that the conditions which resulted in the exposure are corrected and the health of the workers protected?

And finally, a cervical smear. This definitely is a matter of physician-patient relationship. But it is also very much a public health problem. Cervical cancer, practically 100 per cent curable when found in time, last year killed 419 women in Michigan. As one of its functions then, the public health agency develops and promotes programs designed to detect cervical cancer early. They can do so only in close cooperation with local physician groups. It is in this way—and only in this way—that public health and private medicine together can save many lives which otherwise would be lost.

The examples are only a few of many which could be cited but they serve to emphasize the fact that there are many health programs which demand concerted public action for their solutions. That action finds its focus in public health agencies. This is not to say that it is solely of concern to "public health officials," for it emphatically is not. Every parent, every child—yes, and every physician, whether he recognizes it or not—is actively engaged in public health. For public health is literally everyone's business and everyone's responsibility.

A picture window has no appeal for us unless it overlooks our private back yard. We relish our privacy and will defend our right to and need for it, as loudly and as long as the next man. We are more than anxious to leave to each person the contemplation of his own navel, or ingrown toe-nail for that matter. But, when the health of the people is affected—as it often is—by conditions or events with which no individual family can cope, then it is a public responsibility.

That's what's public about health.

ALBERT E. HEUSTIS, M.D., M.P.H.

Veterinary Medical Group Invited to Join MAP

The Michigan Association of the Professions, with all its officers renamed for 1960, announces that the Michigan Veterinary Medical Association will become the fifth state organization member.

The veterinarians also become the first new group to be admitted to membership since MAP was organized.

* * *

THE NEW MAP BOARD of directors, chosen at the first annual Congress of the Professions, re-elected all officers for a second term. William M. LeFevre, M.D., Muskegon, will continue as president; serving with Floyd D. Ostrander, D.D.S., vice president; Elmer J. Manson, A.I.A., secretary, and Frederick Von Voigtlander, P.E., treasurer.

Plans are underway to hold hearings of the various MAP committees in different localities throughout the state. The hearings will be similar to the Pre-Congress Hearings in Detroit where experts in the related fields testified before the committees and recommended activities and policies.

* * *

THE 1960 BOARD of directors of MAP includes the following: for two-year terms—Alden B. Dow (architecture), Elmer J. Manson (architecture), Dr. Floyd D. Ostrander (dentistry), John S. Reed (engineering), N. O. Saulter (engineering), Maxwell F. Badgley (law), Luther R. Leader, M.D. (medicine), William M. LeFevre, M.D. (medicine), John E. Manning, M.D. (medicine), for one-year terms—Adrian N. Langius (architecture), Frederick E. Wigen (architecture), Philip N. Youtz (architecture), Dr. Henry L. Homan (dentistry), Dr. John G. Nolen (dentistry), Richard A. Little (engineering), Frederick Von Voigtlander (engineering), George H. Cary (law), and Gilbert B. Saltonstall, M.D. (medicine).

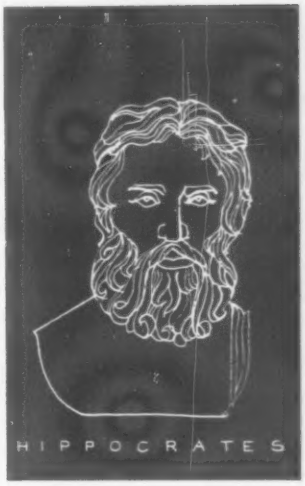
M.D.'s Contribute to New Comparative Medicine Meeting

Doctors of medicine, veterinarians and others in the health field joined together for the first annual Michigan Conference on Comparative Medicine at Michigan State University in March.

This first interdisciplinary meeting dealt with the basic and comparative aspects of cancer, which annually kills more than 250,000 Americans.

Organizer of the conference, W. W. Armistead, dean of the M.S.U. College of Veterinary Medicine, explained that the conference was the first to exchange information on a disease which man shares with the lower animals.

Michigan doctors of medicine who participated on the program were Samuel Albert, M.D., Detroit; H. E. Bowman, M.D., Grand Rapids; N. D. Henderson, M.D., Lansing; A. E. Heustis, M.D., Lansing; Clayton Lewis, M.D., East Lansing; W. J. Nungester, M.D., Ann Arbor; W. L. Simpson, M.D., Detroit; A. J. Vorwald, M.D., Detroit; L. W. Walker, M.D., Lansing.



ACS Unit Elects Officers

The American Cancer Society, Southeastern Michigan Committee, Inc., has elected Harry M. Nelson, M.D., who had been chairman of the Committee, as its president. Dr. Nelson, Detroit, was national president of the American Cancer Society in 1953.

Jerry J. Tobias, chairman of the board of Allen Industries, was named chairman of the Committee's Board of Directors.

Elected as vice-presidents were John R. McDonald, M.D., Detroit, and Mrs. Edward S. Wellock, Bloomfield Hills. Stanford C. Stoddard, vice-president of the Michigan Bank, was named treasurer and Henry Earle, senior vice-president of the First of Michigan Corporation, was elected secretary.

The Board elected Jason L. Honigman, senior partner of the law firm of Honigman, Miller & Schwartz, to be chairman of its executive committee.

The Committee's executive secretary is John L. Swan.

The Society's Southeastern Michigan Committee, Inc., with headquarters at 2895 West Grand Boulevard in Detroit, carries out this program in Wayne, Oakland and Macomb Counties.

Dental Association Studies Prepayment Plan Possibilities

The Michigan State Dental Association held a recent conference in Lansing to examine the possibilities of applying the prepayment concept to dental care in Michigan.

Kenneth J. Ryan, D.D.S., conference chairman, urged dentists to "put forth a plan through their association." He warned dentists against labor or management-operated plans which, he said, constituted "a distinct invasion of our right to control dental health, a right given to us by Michigan law."

Thomas C. Paton, Director of Professional Relations of Michigan Blue Shield, speaking from Blue Shield's experience, asserted that the most equitable and effective dental care plan would be one sponsored by Michigan's dental profession, and incorporating service and community rating principles.

American Medical Women's Association

The American Medical Women's Association will hold its annual meeting, June 9-12, 1960, at The Carillon Hotel, Miami Beach, Florida. Physicians are welcome to attend the scientific sessions. All women physicians attending the AMA meeting are cordially invited to the luncheon on Friday and the dinner on Sunday evening; both are complimentary. Reservations must be received in the Association office, 1790 Broadway, New York 19, New York on or before June 1.

Medical Manpower in Michigan

(Continued from Page 784)

in Michigan increased, but the state's physician-population ratio declined steadily.

2. Michigan's physician-population ratio has been consistently below that of the East North Central states and the United States.

3. When the supply of physicians is compared with effective economic demand for their services, over two-thirds of the states are better supplied with physicians than Michigan.

4. The two medical schools in Michigan are not providing a sufficient supply of graduates to take care of the loss of physicians through retirement and death and the increased need due to the state's expanding population.

5. The movement of physicians in and out of Michigan is accounted for largely by interns and residents.

6. The proportion of physicians in active private practice has decreased since 1930, but this decrease has been made up by an increase in the proportion of physicians whose practice is confined to the hospital.

7. Since 1930, the proportion of physicians who are full-time specialists has shown a striking increase.

8. In Michigan, the partial specialist is no more likely to become a full-time specialist than is the general practitioner.

9. The proportion of full-time specialists who are Board certified has shown a marked increase in the last decade.

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MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Cancer and the Community

Mortality—Michigan is included among the north central states which have the highest cancer death rates in the nation. State mortality statistics show cancer was sixth as a cause of death in Michigan in 1900, second in 1930, and has not changed since. Cancer deaths increased from 1,450 reported in 1900 to nearly 11,000 in 1958. Lung cancer, alone, increased from 347 deaths in 1940 to 1,616 in 1958. Considered apart from other forms of cancer, lung cancer would rank as the sixth leading killer, ahead of diabetes and arteriosclerosis. Cancer causes over 16 per cent of all Michigan deaths—about one in six. Nearly half of the people dying of cancer are under age 65. The death rate is 139 per 100,000 people, compared with a total death rate of 840 per 100,000 from all causes.

Morbidity—There is little knowledge of cancer incidence on a community or statewide basis. The disease was made reportable on May 1, 1947, but because of alleged legal questions, few cancer cases are reported. Some type of cancer reporting is needed to provide meaningful information about people living with cancer. Cancer registers also are needed to add to our knowledge of where, when, and under what conditions cancer is occurring, and for follow-up of patients.

Detection—As well as emphasizing periodic physical appraisal, particularly for older persons, increasing emphasis has been placed upon finding lung cancer earlier with the aid of chest x-ray. However, as experience has shown, by the time most tumors are found on film, it is already too late. There is a time-lag of about three months between the initial interpretation of the screening film and treatment. In 1959, the state health department's four mobile units gave 281,894 chest x-rays, finding 515 suspected lung tumors, or 1.8 per 1,000 persons screened.

In 1954, the state health department Division of Tuberculosis and Adult Health participated for the first time in a cervical cancer screening program, involving local health departments, physicians, pathologists, and cancer societies. In the period 1954-58, nine such programs were held, reaching 8,500 women, finding almost four cases of cervical cancer for every thousand examined. It may be of interest to note that health department's x-ray units screened more than 1,500,000 persons for tuberculosis in the same five-year period, that 8,500 women were checked for cervical cancer in community programs. Yet, in 1958, cervical cancer claimed the lives of 419 Michigan women, while tuberculosis caused 395 deaths.

Care—The registration of radiation devices and radioactive materials indicates the gains made in providing resources for cancer treatment. There is a combined registration total of 105 superficial and deep therapy machines in doctors' offices; 140 in hospitals; six cobalt 60 in operation and eight more in developmental stages; along with 49 hospitals using isotopes for diagnosis and treatment purposes.

While much has been done to provide technical equipment for use in cancer therapy, we have not done so well in other areas. Local health departments are short of staff and able to make only spotty efforts at home nursing for cancer patients. In fact, in 1957, local health departments, serving areas where nine out of ten Michigan people live, reported providing only 4,200 clinical or nursing visits or services for cancer patients. This compares with over 240,000 clinical or nursing services for tuberculosis control in the same year. There is no chronic disease or home nursing service at all for nearly half of the state's population. We also lack adequate chronic disease facilities and quality nursing homes to care for cancer patients in terminal stages. The average terminal patient requires 91 days of care, with about four hours of skilled nursing care a day. This becomes exceedingly expensive when it is provided in an acute general hospital.

Goals—While there is reason to hope for better cancer screening tests and improved treatment methods, much more should be done with the knowledge and weapons already in the arsenal.

We should—

- Sharpen education against quackery, and also emphasize specific types of cancer in the age groups where the incidence is highest, or where known dangers exist.
- Establish some kind of meaningful cancer reporting, and set up case registers.
- Continue to be vigilant in protecting against carcinogenic substances, and also extend efforts in industrial health to combat air pollution, with its possible implications in cancer control.
- Expand cytologic screening to save the lives of women, speed the follow-up of x-ray findings and explore the potentials of sputum cytology.
- Develop chronic disease care facilities, quality nursing homes and home nursing services in many areas where such service now is lacking.

Through expanded cooperative action, much progress can be made against cancer, and at a faster pace.

Cancer Comment

Cancer of the Cervix

Harry M. Nelson, M.D.

By using present established diagnostic methods, cancer of the cervix can be detected early enough so that, with prompt and effective treatment, 85 to 90 per cent will survive five years or more, compared with the present average survival rate of less than 50 per cent. But to achieve this end, the disease must be diagnosed during its preclinical or silent stage.

Just as the periodic health examination is incomplete without a thorough vaginal examination, so the pelvic examination is incomplete without a vaginal cell examination and visualization of the cervix.

Ulcerative and fungating lesions are easily recognized, but the diagnosis should always be confirmed by a biopsy.

The early invasive carcinoma and carcinoma *in situ* deviates very little or not at all from the normal. If carcinoma *in situ* is detected and treated, the cure rate is practically 100 per cent.

Vaginal and cervical smears should be taken and and sent to an approved laboratory for expert interpretation.

* * *

SMEARS MAY BE OBTAINED in several different ways. The pathologist generally provides the directions for the method which he prefers. He also supplies the necessary materials.

The patient should not take a douche before coming to the office. Always obtain the smear prior to the pelvic examination and before any instrumentation is attempted. It should be fixed immediately in 95% alcohol and ether.

Scraping material directly from the cervix is an excellent way of obtaining a smear for early diagnosis of that organ. A spatula, tongue blade, or cotton applicator may be used. It is important to get the cells from as far up in the canal as is possible. But one must avoid scraping vigorously.

Some pathologists prefer at least one smear from the posterior fornix and one from the cervix (scraping). Two smears are better than one.

The tampon method of obtaining smears does not appear sensitive enough for general use.

* * *

WHILE THE PATHOLOGIST CAN BE counted on to do his part in preserving the doctor-patient relationship, he requires specimens that are properly collected and preserved. It should be remembered that he must correlate the cytological findings with the biopsy as well as with clinical status of the patient.

Most positive smears, as is to be expected, come from symptomatic patients who consult the physician because of the spotting, discharge or frank vaginal bleeding. But it is the positive smears discovered in asymptomatic patients, showing no physical indications, that make the laborious work of screening all patients so eminently worth while.

In a recent study of a group of almost 16,000 asymptomatic women, examined at the Yates Memorial Clinic, Detroit, who underwent routine vaginal cell examinations, an accuracy of 87.8 per cent has been demonstrated.

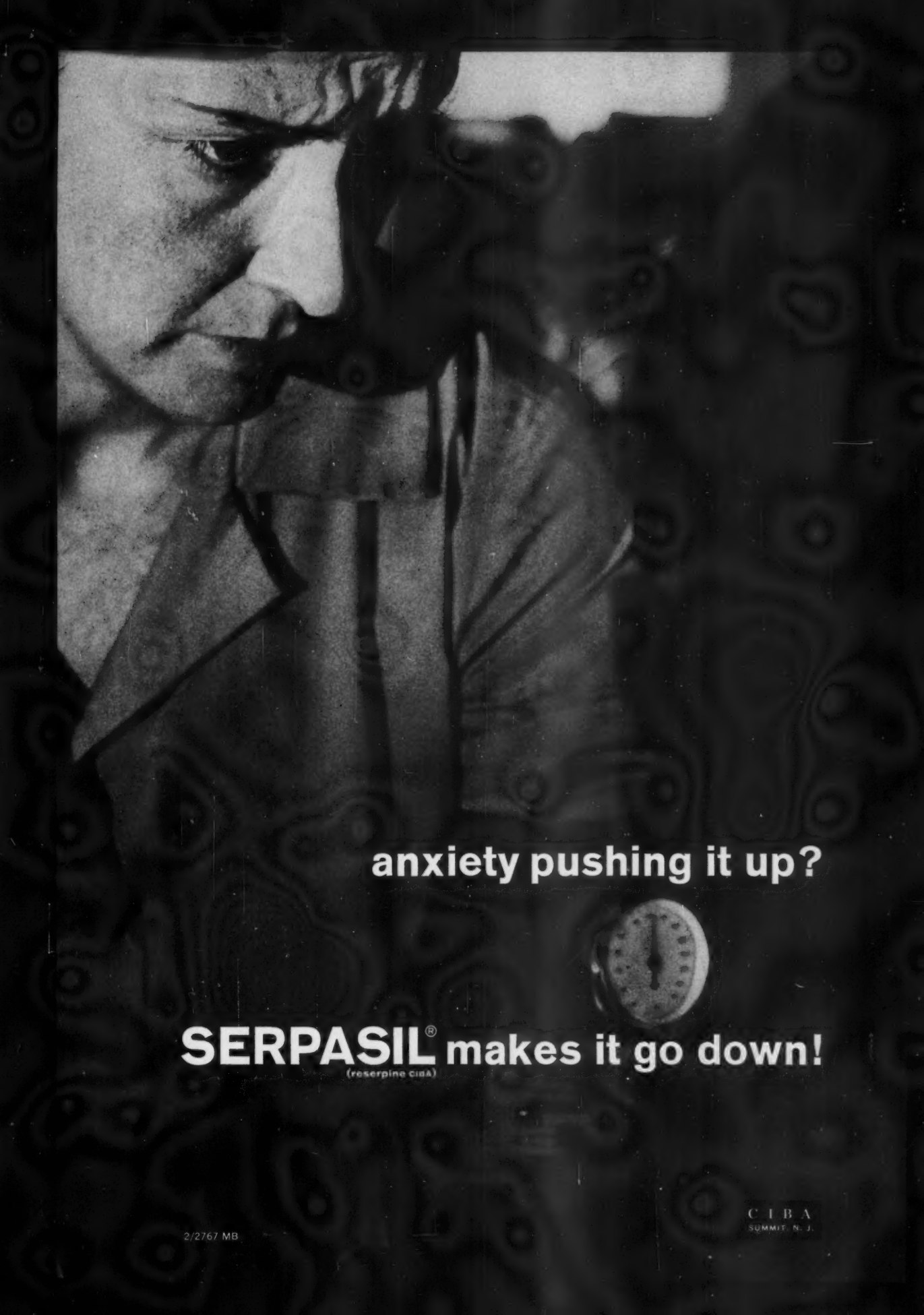
It is particularly significant to note that a quarter of the invasive and approximately three-quarters of the pre-invasive carcinomas of the cervix were not recognized on vaginal inspection. In each of these cases, before the smear was found to be positive, a thorough history was taken and a physical examination performed, including a pelvic examination with direct visualization of the cervix, by a staff physician, at which time no evidence of neoplasm was found. Without the smears as a routine screening procedure, these lesions would have been missed at a stage most amenable to cure.

* * *

HISTORY AND PHYSICAL EXAMINATION are not, therefore, reliable methods for the diagnosis of cancer of the cervix. Routine cell examination for uterine cancer has been found a most effective diagnostic aid in cancer detection and is credited with the primary detection of 42.8 per cent of all cancer of the cervix at the Yates Clinic.

A definitely positive cell examination indicates that the patient has cancer. The clinician must then assume the responsibility of proving it beyond a doubt by obtaining a proper biopsy. The most effective way to achieve this is to hospitalize the patient for cold conization and a diagnostic curettage. This, in our experience, is the only sure method of obtaining sufficient tissue and of determining the extent of the lesion.

So accurate is the vaginal cell examination in the diagnosis of cervical cancer, that continued follow-up of every false positive report should be resumed until each and every case has been resolved to the satisfaction of all concerned.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Excerpted from J.A.M.A., Aug. 29, 1959

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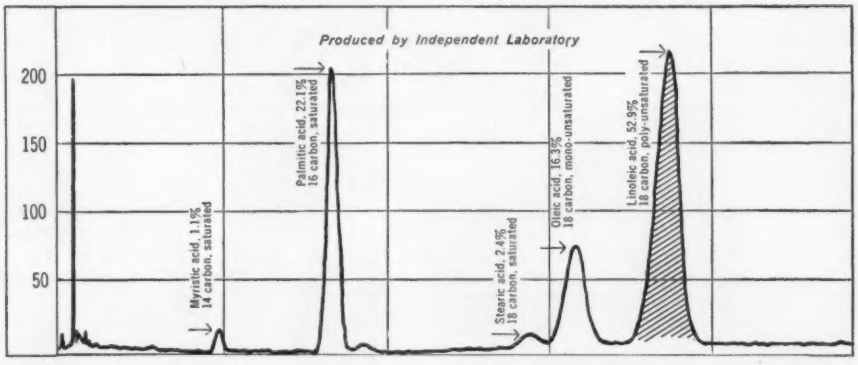

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*Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability group.

EDITORIAL COMMENT

Aged Deserve Lasting Help

Detroit Free Press, March 24, 1960

HEALTH CARE for the elderly already has become one of the major political issues of this presidential election year.

All problems of the aged have been under wide study and discussion for several years. The medical profession, deserving of credit for first recognizing that the growing numbers of aged would create specific problems, began extensive studies about 10 years ago in a new field it elected to call geriatrics.

Lately, however, the field has been pre-empted by some politicians who see the problems mostly as an opportunity to gather votes with an issue seemingly as invulnerable as motherhood and patriotism.

The Forand bill, which would provide free hospitalization and medical care for Federal social security pensioners, has Congress and the two major political parties in turmoil.

The topic has become super-heated by those who see the issue of medical care as a black-or-white choice between all-out "socialized medicine" for all elderly people or doing absolutely nothing to help that percentage of the aged who are in really dire need.

To those whose concern for the aged is more responsible and reasoned, there ought to be a middle ground on which the pressing problems can be solved immediately without making the elderly the pawns in an opportunistic political scramble for votes, and which also will provide time for the needed observation and formulation of long-term solutions to problems that will continue to exist.

* * *

FIRST OF ALL, portraying all retired people as living in poverty-stricken misery, scarcely honors those many retired people who have managed their lives (with considerable assistance from the ever-increasing trend to personal or organized pension plans) so as to provide themselves with at least a reasonably comfortable life.

This fast-growing tendency of private business and industry to assist people in the long-range task of providing for their so-called nonproductive years also should do much to alleviate what now appears to be a mass problem.

Many elderly persons with severe problems and desperately in need of immediate assistance were caught in the interval between the social era when sons and daughters provided for their aged parents and the more modern time when social security and private pension plans took over the job.

During the last few years when the problems—material, medical and personal—of the aged have been under study, the situation has changed constantly. No definite patterns of long-range need have been agreed upon by the experts. Therefore, the adoption of solutions on a mass scale appears unwise.

* * *

IF QUICK REMEDIES for the many who are in truly abject circumstances are needed, there are many alternatives to a massive program of compulsory health insurance—which would carry with it the bureaucratic high costs, inefficiencies, inequities and inflationary effects of all such blanket schemes.

Combatting inflation—the retired person's greatest enemy—might be considered the most pressing task.

Without doing any harm whatsoever, the earned income allowable under Federal social security could be increased greatly, thus permitting many who want to work to do so. Tax relief for the aged and for those who contribute to their support could be granted. President Eisenhower's known wish to provide voluntary health insurance, with assistance to those subject to catastrophic illness and unable to buy such insurance, is another worthwhile approach.

Such remedies might turn out to be a permanent solution to the changing needs of the aged.

And at least these and other means could provide quick relief for those who need it most and give the nation the time it needs to meet in a considered and rational manner its recognized and accepted responsibilities to its valued and respected senior citizens.

New Dimension

The PR Doctor, March, 1960

The Michigan State Medical Society has added an unusual dimension to medical TV production with its series of live regional or "outstate" telecasts, which have the advantage of providing county societies with a locally oriented public relations vehicle.

Titled "Family Doctor," three of the four planned productions have already been presented in various Michigan cities—the first show in Detroit during the 1958 MSMS Annual Session, the second in April, 1959, from Kalamazoo, and the third last fall from Grand Rapids. The series is being produced by

(Continued on Page 802)

New Dimension

(Continued from Page 800)

MSMS, the Michigan Health Council, and the local county medical society, and has featured dramatizations of the facilities and services obtainable in a modern doctor's office as well as demonstrations of surgical procedures.

With more and more societies realizing the virtues of medical broadcasting, the immediate problem becomes one of bridging the gap between the TV studio's idea of what constitutes high quality medical programming, and the individual society's own ideas on how best to utilize medical "talent." Here again the answer lies in closer ties with local TV producers.

In order to insure the best possible programming with the resources available, medical societies should sit down with TV experts, get their suggestions and take advantage of their "know-how" in the field. This is obviously the best policy for all concerned!

The Michigan Health Council's M.D. Placement Bureau will help Michigan doctors obtain a locum tenens to cover the office while a doctor might be on an extended leave from the office or absent on a holiday. Inquiries may be addressed to M.D. Placement Bureau, Michigan Health Council, 712 Abbott Road, East Lansing.

Obstetrical Brevits

(This column is sponsored by the Michigan Society of Obstetrics and Gynecology.)

On Maternal Mortality Review and Staphylococcus Infections

For quite some years, men in Michigan have reviewed Maternal Mortality Statistics. The Evaluation committee is part of this study. Unidentifiable case histories are sent from the State Health Department to this committee and the cause of death is classified and discussed. Doctor Norman Miller has been chairman. The original committee consisted of Drs. Norman Miller, George Kamperman, Charles Stephenson and for a while Alexander Campbell. When Doctor Kamperman asked to be relieved I was fortunate enough to replace him. The experience has been one of the highlights of my life.

We meet in Doctor Miller's office on a Thursday afternoon and read the case histories of the obstetrical fatalities. All of us do, or have done, obstetrics and these presentations often frighten us very personally as we think of the patient and the physician involved. After working the afternoon we adjourn to dinner and informal talk. Doctor Behney of the Health Department, a certified obstetrician, and a man of private obstetrical experience, has been a fine addition to our group. He replaced Doctor Alexander Campbell of Grand Rapids who many of you fondly remember.

Out of these reviews and discussions pictures appear. The polio deaths during pregnancy and the results of the Salk Vaccine; in October of 1957, the frightening death rate from influenza (better than 10 per cent of the total maternal deaths for that year were from this disease); in 1958 we saw a new threat appear—the staphylococcus puerperal mortality. Seeing these puerperal infections occur brought back to us memories of previous days, days before antibiotics, days that we hoped were gone forever. The helpless feeling of attending sepsis, uncontrolled, is a real nightmare—we remembered.

We called a meeting of the State Maternal Health Committee and presented papers on the handling of sepsis and its reference and application to the present situation. These papers will be presented in forthcoming brevets. Further progress of the possible epidemic will be presented as the picture unfolds.

Improved technique helps combat puerperal sepsis. Simmelweis, years ago, discovered that if attendants washed their hands in chlorine water before a delivery the mortality was reduced from ten to one per cent. However, important as it is, technique never eliminated sepsis until after the advent of antibiotics. Then for several years, except for septic abortion, thrombophlebitis and neglected cases, the incidence of serious infection was tranquilizing.

If we have an antibiotic "breakthrough" we must find another answer. For this reason we urge you to cooperate with the regional consultants, get autopsies and cultures wherever infection is suspected and cooperate with local infection committees. If possible send tissues from autopsies to the tissue registry in Ann Arbor. Doctor French, head of the University of Michigan Pathology Department, is cooperating in this study.

Needs Consent of Patient

Dear Doctor:

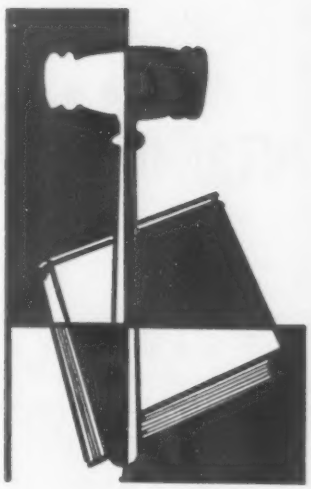
Your request for legal opinion presents a state of facts which can be summarized as follows: A young woman was admitted to a local hospital suffering from a physical illness. She appeared to be despondent and members of the staff felt that she might become suicidal. The hospital administration requested of her physician that he obtain psychiatric consultation. The physician advised consultation but both the patient and her relatives refused to consent. Could the physician arrange such consultation against the wishes of the patient and her relatives?

In my opinion the foregoing question must be answered in the negative.

To bring another physician into the picture under such circumstances would not only deprive the patient of a right of free choice of physicians but would be apt to place the attending physician in the position of disclosing privileged matters and of violating the patient's right to privacy. It would also place the consulting physician in the position of an unauthorized volunteer. In short, I am of the opinion that the physician-patient relationship cannot be established, even on a consulting basis, without the consent of the patient or of someone qualified to consent in her behalf.

Although, perhaps, beyond the scope of your inquiry, it should be pointed out that the refusal to accept consultation might well justify the attending physician's withdrawal from the case, upon proper notice, if he felt that continued proper handling of the case required consultation.

Very truly yours,
LESTER P. DODD
Legal Counsel, MSMS



New York Verdict

This case was an action by a patient of a private hospital against the owner and operator of the hospital and the attending surgeon for injuries allegedly sustained as a result of the defendant's failure to prevent, or to detect within a reasonable time, the infiltration into his tissue of a drug being administered by a resident physician as a component of an intravenous injection. The jury rendered a verdict of $22,500 for the plaintiff. On appeal, the New York Supreme Court, Appellate Division, Second Department, reversed the judgment against the surgeon. The judgment against the owner and operator of the hospital was also reversed, and a new trial granted unless the patient would stipulate to reduce the judgment to $17,500. The Court held that the surgeon had the right to rely upon the competency of the hospital staff, particularly that of the resident physician, to insert the needle properly and to check frequently the intravenous flow after the drug had been added. (*The Citation*, December 3, 1959).

IN MEMORIAM

ROBERT E. ANSLOW, M.D., sixty-four, a Detroit physician for forty years, died March 16, 1960.

A native of Ionia, Doctor Anslow was a graduate of Olivet College and received his medical education at the University of Michigan. He was an eye, ear, nose and throat specialist.

In addition to his medical affiliations, he was a member of the Detroit Boat Club, Grosse Pointe Congregational Church, Phi Rho Sigma Society and the Alumni Association of the University of Michigan.

M. W. BUCKBOROUGH, M.D., fifty-six, a South Haven physician, died March 25, 1960.

Born in Sault Ste. Marie, Doctor Buckborough was a graduate of Albion college and the University of Michigan Medical School.

Doctor Buckborough was chief of staff at South Haven Hospital.

He was a boat enthusiast, a member and one of the founders of the South Haven Yacht Club and a member of the River Bend Boat Club. His other memberships included South Haven First Methodist Church and the Masonic Order.

LEWIS M. CAREY, M.D., eighty-three, a former Detroit-Pontiac area physician for forty-three years, died in Smyrna Beach, Florida, February 29, 1960.

Doctor Carey, born in Port Huron, was graduated from the old Michigan College of Medicine and Surgery, Detroit, now Wayne State University College of Medicine.

He was a Spanish-American War veteran.

Doctor Carey was a member of the Doctor William Beaumont Foundation, St. Clair, Michigan. Other affiliations included life membership of Hazen S. Pingree Camp 5, United Spanish War Veterans, New Smyrna Beach, Florida, Community Church and membership in the Alumnus of Wayne University College of Medicine.

CLARENCE D. CHAPIN, M.D., eighty, a Columbiaville physician since 1904, died March 20, 1960.

Doctor Chapin was a graduate of the Detroit Medical College.

In 1954, Doctor Chapin received a Fifty-Year Award from the Michigan State Medical Society, honoring him for having practiced medicine for half a century.

He belonged to Lapeer Post No. 16, American Legion and the Columbiaville Rotary Club.

KENNETH H. COWDERY, M.D., forty-nine, St. Joseph physician for twelve years, died February 22, 1960.

Doctor Cowdery was born in Warren, Ohio, attended Western Reserve University in Cleveland and was graduated from medical school in 1939. His internship was taken in Cleveland City Hospital and his residency at City Hospital in Glenville, Ohio. He enlisted in the Army in World War II and became a battalion surgeon in a ski troop division. Upon

(Continued on Page 808)

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Special Advantages	Supportive Clinical Observation	...and for additional evidence
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IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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KENNETH H. COWDERY, M.D.

(Continued from Page 806)

returning to civilian life, he established a practice at Huron, Ohio, where he served until moving to St. Joseph.

Doctor Cowdery was a staff physician at Mercy and Memorial hospitals, and served one term as chief of staff at the St. Joseph institution.

Fraternal and social affiliations included the Masons, St. Joseph Kiwanis, the St. Joseph River Yacht Club, the Berrien Hills Country Club and Phi Rho Sigma.

FRED H. DRUMMOND, M.D.,

sixty-eight, Kawkawlin general practitioner for thirty years, died March 31, 1960, after a brief illness.

Doctor Drummond was an MSMS Councilor from the 10th District for ten years. He was also past chairman of the Publication Committee of the MSMS Council and a Past President of the Bay-Arenac-Iosco County Medical Society.

A native of Bay City, Doctor Drummond graduated from Northwestern University, Chicago, in 1920, and interned at Kansas City General Hospital, Kansas City, Missouri. He served in the Army Medical Corps in 1918.

Dr. Drummond served as chief of staff for both Mercy Hospital and General Hospital in Bay City. Memberships included the American Legion and Sigma Chi fraternity.

HAROLD J. DAMSTRA, M.D.,

fifty-seven, a Grand Rapids physician and member of the staff of Butterworth hospital thirty years, died February 26, 1960.

He was also a staff associate of Blodgett Memorial hospital and specialized in obstetrics and gynecology. Doctor Damstra, a native of Holland, practiced at Wayland from 1930 to 1938, at which time he moved his office to Grand Rapids.

He was a graduate of Hope college and Northwestern University School of Medicine.

He served in the army medical corps from 1942 to 1945, spending two years in the European theater.

In addition to his medical affiliations, he was a member of the Central Reformed church and South Kiwanis club.

CHARLES A. NEAFIE, M.D.,

seventy-seven, for thirty-five years Pontiac health director, died March 23, 1960.

Doctor Neafie was a native of New York City. He interned in New York hospitals, after graduating from University of Maryland in 1909. In 1912, he practiced as a resident physician at Pontiac State Hospital.

In 1918, Doctor Neafie became the city's first full-time health officer, a post he held until his appointment as director of health in 1921. He retired four years ago.

Doctor Neafie was cited for outstanding services four years ago by the Oakland County Medical Society. He is a past president of the Oakland County Medical Society and past exalted ruler of Elks Lodge No. 810.

Any firm which refuses to hire persons aged forty or over is ineligible for Newark, N. J., municipal contracts.

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

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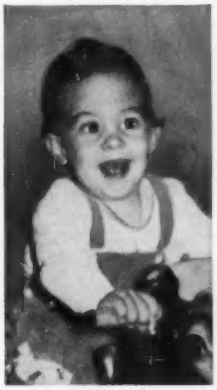

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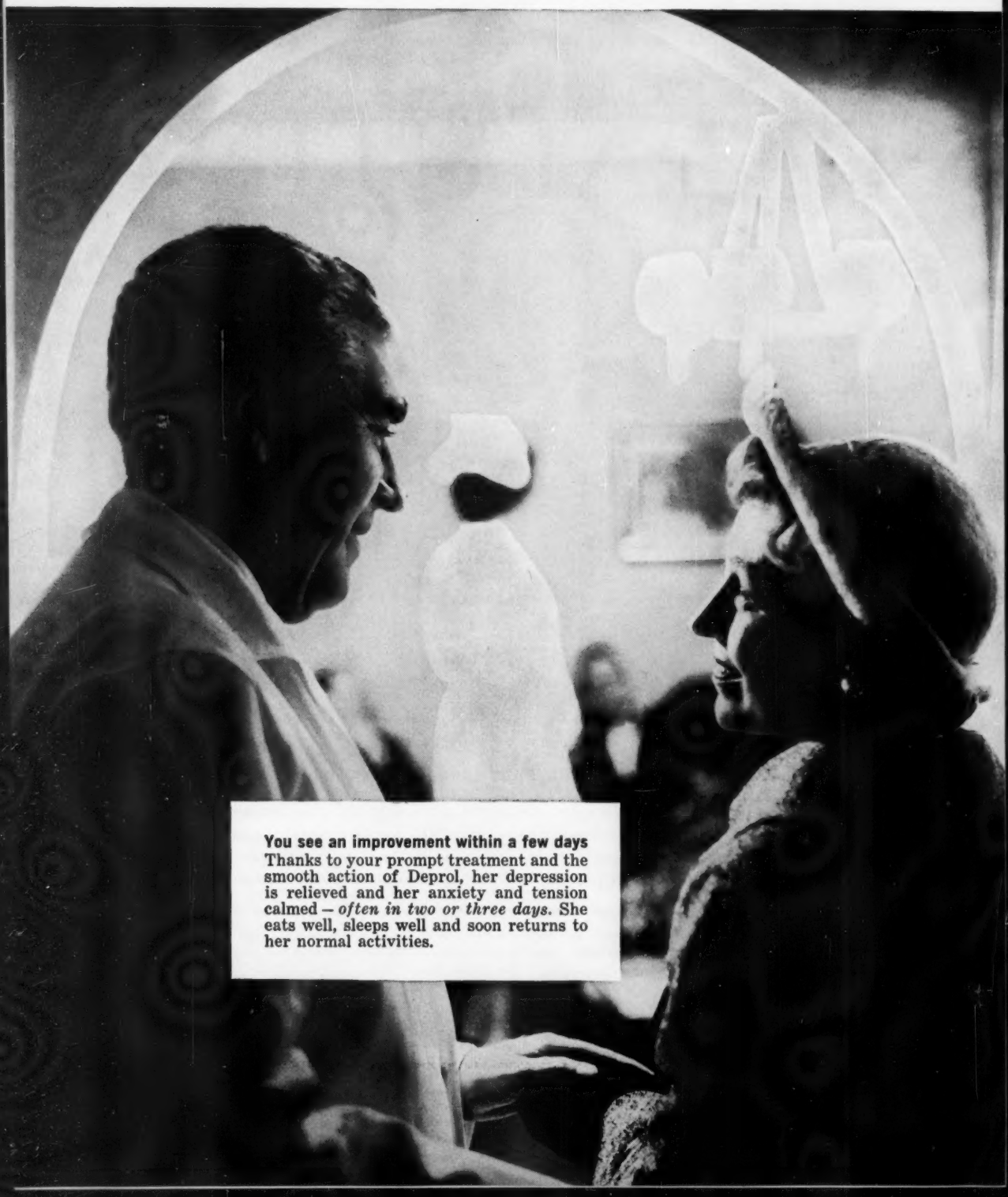


You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in two or three days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

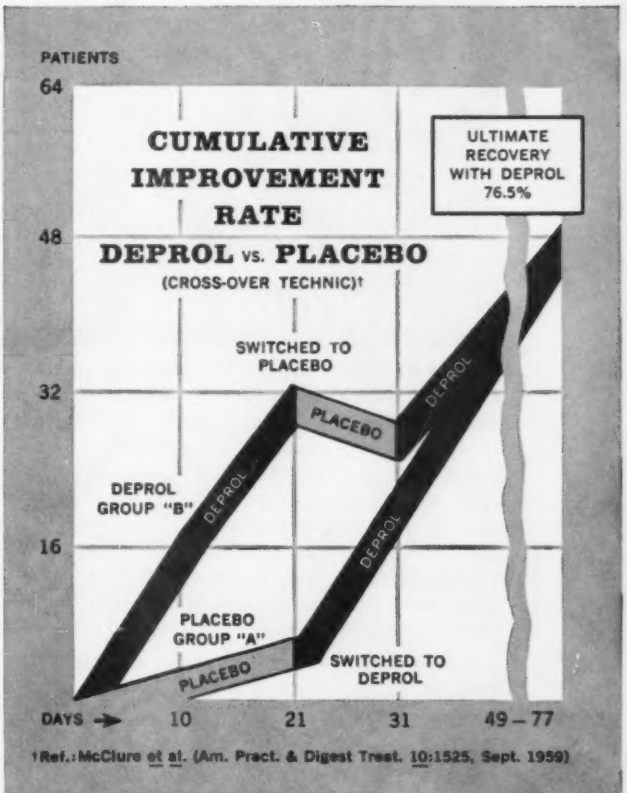
Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within two or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within two or three days.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.



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AMA Forms Fifty-Year Club

The American Medical Association has announced the establishment of a Fifty-Year Club, being organized primarily as a social function for physicians who have been in practice fifty years or more. There are no dues. The plans are to have a room set aside at each clinical meeting of the American Medical Association for members to meet. A luncheon or breakfast will be decided upon at each meeting. Members will be given fifty year buttons. Usefulness and benefits will depend on the desires of the membership.

J. H. McCurry, M.D., of Cash, Arkansas, is the organizer. He would be pleased to receive a note stating from doctors interested in becoming a member, give the date of graduation with the printed name and address.

WRITES MANUAL—Robert M. Heavenrich, M.D., Saginaw, Chairman of MSMS Child Welfare Committee, is the author of a book entitled, "Care of Children in Hospitals," published by the American Academy of Pediatrics. Dr. Heavenrich is a member of the Academy's Committee on Hospital Care which prepared the manual to help communities with the problem of planning hospital construction and organizing and operating pediatric service in a community hospital. Copies of the manual will be distributed to all Michigan pediatricians and hospitals with the cooperation of the Michigan Branch of the American Academy of Pediatrics and the Michigan Health Department.

OFFER HELPFUL CARD—Forty thousand wallet-sized cards with 12 simple rules for emergency childbirth for expectant mothers are being distributed by the Michigan Office of Civil Defense. The cards were developed by the MSMS Committee on National Defense, Max L. Lichter, M.D., Melvindale, Chairman.

The cards will eventually be distributed to patients by local physicians.

HONOR GALESBURG G.P.—James C. Breneman, M.D., of Galesburg, was named winner of the 1960 Ross awards of $1,000.00 given annually by the American Academy of General Practice for outstanding scientific articles published in GP, the association's monthly journal.

HEADS STATE GROUP—Joseph A. Witter, M.D., of Highland Park, began duties in March as the new president of the Michigan Chapter of the American College of Surgeons. He assumed office at the eighth annual meeting at Flint.

The new president is a graduate of the University of Michigan Medical School and has been practicing since 1934. He is chief of the Department of Surgery at the Highland Park General Hospital.

NATIONAL PRESIDENT—Ross V. Taylor, M.D., of Jackson, was chosen president-elect of the American Society of Internal Medicine at its meeting in San Francisco April 1. Doctor Taylor was president of the Michigan organization in 1958, and will succeed to the AAIM presidency in April, 1961.

AMA GOLF TOURNAMENT—The American Medical Golfers Association will hold its 44th Annual Tournament at the Diplomat Hotel and Country Club, Hollywood, Florida, Monday, June 13. All MSMS members, who are golfers, are invited to participate.

MTA RESEARCH GRANTS—The Michigan Tuberculosis Association will award grants-in-aid to qualified persons wishing to carry out research in the field of tuberculosis and pulmonary disease, announced John W. Towey, M.D., of Powers, Michigan, chairman of the Medical Research and Education Committee of MTA.

Application forms for grant-in-aid of medical research may be obtained from: The Chairman of Medical Research & Education Committee, Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14.

OFFER BOOKLET—A question-and-answer booklet about drug prices is offered by the Pharmaceutical Manufacturers Association as a public service. Copies may be obtained from the Association, 1411 K Street, NW, Washington, D. C.

SPEAKS—Samuel J. Levin, M.D., Detroit, participated in a symposium on "The Allergic Child" at New Haven, Connecticut, April 6.

NEW FEDERAL PUBLICATIONS—The U. S. Department of Health, Education and Welfare has published two new numbers of "Health Statistics" from the U. S. National Health Survey. Series B—No. 13 deals with "Heart Conditions and High Blood Pressure," while Series D—No. 1 deals with "A Study of Special Purpose Medical-History Techniques."

SEEK FUNDS—The Dartmouth Medical School has launched a drive for $10,000,000 in capital funds. Among principal objectives of the fund campaign are the construction of a new $3,000,000, seven-story Medical Science Building, now under way, and construction of library and auditorium facilities.

HELPS HOPE COLLEGE—John Heneveld, M.D., retired Muskegon doctor and a past president of the Muskegon County Medical Society, recently gave an endowment, valued at $200,000, to the Hope College Endowment Fund.

TAKES NEW POST—Charles I. Herrington, M.D., of Bad Axe, has been named the first full-time medical director of the Huron County Health Center. The appointment had been authorized by the State Welfare Department and made by the Huron County Department of Social Welfare.

APPOINTED—David Jacknow, M.D., Detroit, has been appointed to the Advisory Council of the State Industrial Safety Commission by Governor Williams.

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports that the following topics were covered during the month of March on the weekly Sunday morning program over WJBK-TV in Dertoit: Michigan Clinical Institute, Nephrosis, Epilepsy and Tuberculosis.

M.D.'S ART EXHIBIT—The 23rd annual exhibition of art works by American physicians will be held June 13-18 at the Miami Beach Exhibition Hall and Auditorium. Held in conjunction with the annual convention of the American Medical Association, the show will include over 300 works of art in oil, water color, sculpture, crafts, photography and lithography. Prospective exhibitors may obtain further information from Kurt F. Falkson, M.D., Secretary of the

American Physicians Art Association, 7 East 78th Street, New York City.

WSU RESEARCH GRANTS—The Wayne State University's Board of Governors has accepted a grant of $127,480 from the U. S. Public Health Service, National Institutes of Health, for six projects. Included was $80,736 to continue a survey in cervical cancer; $30,404 will be used to continue the postgraduate training program in psychiatry.

The Michigan Cancer Foundation gave $26,497 for research in lung cancer.

DOCTOR DORSEY LECTURER—John M. Dorsey, M.D., professor and chairman of Wayne State University's department of psychiatry, presented the final lecture in the 1960 Leo M. Franklin Memorial Lecture Series. "The Growth of Self Insight," was the topic for Doctor Dorsey.

ELECT HOSPITAL OFFICERS—The Detroit Memorial Hospital Board of Trustees has elected the following officers for 1960: Mervyn G. Gaskin, president; Gordon K. Glasgow, M.D., vice-president; Simpson C. Leonard, secretary; William J. Thomas, treasurer; and James E. Lofstrom, M.D., assistant secretary-treasurer.

EXPANDS WARNINGS—A new trade advisory service on label warnings for drugs and therapeutic devices available without a doctor's prescription was announced today by the Food and Drug Administration. A compilation has been printed of such label warning statements for guidance of drug manufacturers in devising labels which meet the requirements of the Federal Food, Drug, and Cosmetic Act for "such adequate warnings . . . as are necessary for the protection of users.

FDA said consumers can take advantage of this health protection only by reading carefully and following the directions for use on the label of drug products and by paying particular attention to the warning statements.

MHC PLACEMENT—The Michigan Health Council reports that it has assisted Don G. Davis, M.D., to a practice in Kalamazoo.

OFFER CAMPING—The second annual summer camp program for children with epilepsy will be held in June at the National Children's Rehabilitation Center at Leesburg, Virginia. Applications for admission are now being accepted, according to Charles Kram, M.D., director.

PROGRAM CHAIRMAN—James L. Wilson, M.D., Ann Arbor, will be program chairman for the First International Conference on Congenital Malformations to be held in England in July. Under auspices of the National Foundation, the conference is designed to focus world-wide attention on the subject of birth disorders.

MEET IN EUROPE—The 6th International Congress of Internal Medicine will be held August 24-27 at Basle, Switzerland. Principal subjects will include Pathogenesis and Therapy in the Edema and also Enzymic Regulations in the Clinic.

Sixty-eight Federal Emergency Hospital units like this one are stored in Michigan for possible use in Civil Defense emergencies. The "unseen" hospital units were on display during March and April at Kalamazoo, Bay City, Gaylord, Marquette, Ann Arbor, Grand Rapids and Lansing for doctors, CD workers and the public officials. The photo was taken at the U-M campus.

NURSING RESEARCH—The U. S. Public Health Service has announced four new grants for research in nursing, including one to Mable A. Wandelt, of Wayne State University School of Nursing.

NEW APPOINTMENT—Edward J. Connors, assistant professor of hospital administration at the University of Michigan, has been appointed superintendent of hospitals at the University of Wisconsin.

CANCER CONFERENCE AT WAYNE—National authorities discussed the nature and treatment of cancer at a symposium April 6 held at Wayne State University College of Medicine.

Eugene Pendergrass, M.D., University of Pennsylvania Hospital, gave the opening paper on "Treatment of Inoperable Carcinoma of the Breast." Dinner speaker was Shields Warren, M.D., Harvard University on "Cancer Research—Tomorrow's Cure." Other speakers were Murray Copeland, M.D., Georgetown University Medical Center, "Benign Tumors of the Breast;" Harry W. Southwick, M.D., University of Illinois, "Cancer of the Head and Neck," and Howard Ulfelder, M.D., Harvard University, on "Carcinoma of the Cervix—Early Diagnosis and Treatment."

DR. POLLARD SPEAKS—The American Gastroenterological Association held its annual meeting in New Orleans April 1-2. H. Marvin Pollard, M.D., the president of the Association, is professor of internal medicine at the University of Michigan. He gave his presidential address April 2. A number of Michigan physicians participated.

PATHOLOGY REPORT—John R. Cummings, M.D., of the University of London and the Institute of Neurology, Queen Square, London, was a guest lecturer at the University of Michigan Medical Center, March 21. His topic was "Cerebral Lipidoses." The program was sponsored by the Department of Neurology, in the University Hospital.

SPEAKS AT WORKSHOP—I. M. Altshuler, M.D., St. Clair, was a speaker at the Michigan Congress of Parents and Teachers "Family Life Workshop" held this spring at Western Michigan University.

HIDDEN HAZARDS—The American Medical Association has published a 20-page booklet, "Hidden Hazards" about the unlabeled poison problem. Latest U. S. statistics show that as many as 1422 persons died in a year from accidental overexposure to packaged chemicals in one year.

The American Medical Association is urging all state and county medical societies to launch educational programs based on this booklet as well as to inform congressmen of their official support of the bill.

To obtain the booklet, write American Medical Association, 535 North Dearborn Street, Chicago.

PLAN NEW SERVICE—The Board of Governors of Wayne State University, March 16, accepted gifts and grants totaling $288,400 for various purposes. The largest single gift was $132,469 from the McGregor Fund, another from the Ford Foundation was $114,170. Another $19,612 came from the U. S. Public Health Service, National Institutes of Health and also included was $5,000 from the Research Corporation.

A total of $111,969 of the McGregor Fund grant will be used over a three-year period to develop an out-patient service for emotionally disturbed children at Receiving Hospital under the direction of James H. Graves, M.D., of the University's College of Medicine.

MEDICAL MEETINGS U.S.A.

The Forty-Fifth Session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, June 6-24, Saranac Lake, New York.

Seventh Institute on Science in Law Enforcement, June 20-25, Western Reserve University, Cleveland, Ohio, announced by Oliver Schroeder, Jr., director of Western Reserve University Law Medicine Center.

Two-week Course in Neuromuscular Diseases of Children with Special Emphasis on Cerebral Palsy, June 20 to July 1, Cook County Graduate School of Medicine, Chicago; for information, write to John J. Neal, Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago.

The Second Annual Oregon Cancer Conference, July 7-8, Portland, Oregon; for information write Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 2164 S.W. Park Place, Portland 5, Oregon.

Ninth Annual Symposium for General Practitioners on Tuberculosis and other Pulmonary Diseases, July 11-15, Saranac Lake, New York; for information write John N. Hayes, M.D., General Chairman, Box 627, Saranac Lake, New York.

13th Annual Summer Institute on Survey Research Techniques, July 18-August 13, University of Michigan Survey Research Center, Ann Arbor; for information write Survey Research Center, University of Michigan, Ann Arbor.

14th Annual Rocky Mountain Cancer Conference, July 20-21, Denver Hilton Hotel, Denver, Colorado.

Third International Congress of Physical Medicine, August 21-26, at The Mayflower Hotel, Washington, D. C.; for information write Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2.

Annual Otolaryngologic Assembly, September 24-30, University of Illinois College of Medicine Department of Otolaryngology, Chicago, Illinois; for information write direct to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Eighth Congress of the Pan-Pacific Surgical Association, September 27-October 5, Honolulu, Hawaii; for information write F. J. Pinkerton, M.D., Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

13th Annual Conference on Electrical Techniques in Medicine and Biology, October 31-November 1-2, Sheraton-Park Hotel, Washington, D. C.

67th Annual Convention of the Association of Military Surgeons of the United States, October 31, November 1-2, Mayflower Hotel, Washington, D. C.

ATTENDS MEETINGS—James M. Robb, M.D., Detroit, attended several society meetings when he recently visited in Florida. He attended sessions of the American Otological Society, American Triological Society, American Bronchoesophagological Society, American Laryngological Association, and the seventh annual Pan-American Congress of Oto-rhino-laryngology and Bronchoesophagology.

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Michigan Authors

Edward J. Hill, M.D., Detroit, "New Method For Holding Nasal Tubes in Position," *Journal of the American Medical Association,* March 5, 1960.

Hugo Araujo, M.D., Asuncion, Paraguay, **William S. Wilson, M.D.,** and **Ralph L. Brandt, M.D.,** Ann Arbor, "Coarctation of the Aorta with Secondary Pulmonary Hypertension and Electrocardiographic Evidence of Right Ventricular Hypertrophy," *University of Michigan Medical Bulletin,* December, 1959.

Robert J. Bolt, M.D., and **H. Marvin Pollard, M.D.,** Ann Arbor, "An Evaluation of the Role of Anticholinergic Drugs in the Treatment of Duodenal Ulcer," *University of Michigan Medical Bulletin,* December, 1959.

Bruce Proctor, M.D., Detroit, "Indications for Surgery in Middle Ear Deafness," *Illinois Medical Journal,* February, 1960.

David McCubbrey, M.D., and **E. Thurston Thieme, M.D.,** Ann Arbor, "Perforation of the Gallbladder," *A.M.A. Archives of Surgery,* February, 1960.

E. S. Gurdjian, M.D., F.A.C.S., W. G. Hardy, M.D., and **D. W. Lindner, M.D.,** Detroit, "The Surgical Considerations of 258 Patients with Carotid Artery Occlusion," *Surgery, Gynecology and Obstetrics,* March, 1960.

John H. Bihl, M.D., Northville, "The Effect of Pregnancy on Hepatolenticular Degeneration (Wilson's Disease), *American Journal of Obstetrics and Gynecology,* December, 1959.

Peter A. Martin, M.D., Detroit, "On Scierneuropsia, a Previously Unnamed Psychogenic Visual Disturbance," *The Journal of the American Psychoanalytic Association,* January, 1960.

George S. Schools, M.D., Richmond, Virginia, and **Winthrop N. Davey, M.D.,** Ann Arbor, "Needle Biopsy of the Parietal Pleura," *University of Michigan Medical Bulletin,* January, 1960.

James H. Davis, M.D., and **Donald R. Korst, M.D.,** Ann Arbor, "Mongolism and Leukemia," *University of Michigan Medical Bulletin,* January, 1960.

Lloyd J. Lemmen, M.D., Muskegon, and **Ernest E. Reigh, M.D.,** Pittsburgh, Pa., "Surgical Management of Spontaneous Occlusive Disease of the Internal Carotid Artery," *University of Michigan Medical Bulletin,* January, 1960.

Leopold Liss, M.D., Ann Arbor, "A Perfusion Chamber for Tissue Culture," *University of Michigan Medical Bulletin,* January, 1960.

Conrad A. Proctor, M.D., Ann Arbor, "The Development of Sensory Cell Innervation in the Inner Ear," *The New Physician,* March, 1960.

Thomas Francis, Jr., M.D., Ann Arbor, "Research in Preventive Medicine," *The Journal of the American Medical Association,* March 5, 1960.

The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

WORTH QUOTING

"The purpose of the medical reader is to broaden his view, not merely to find a simplified set of rules for earning his bread and butter."—JOSEPH GARLAND, M.D., editor, *New England Journal of Medicine.*

HERITABLE DISORDERS OF CONNECTIVE TISSUE. By Victor A. McKusick, M.D., Associate Professor of Medicine, Johns Hopkins University School of Medicine; Physician, Johns Hopkins Hospital; Assistant Professor of Epidemiology, Johns Hopkins University School of Hygiene and Public Health, Baltimore. Second Edition. Illustrated. St. Louis: C. V. Mosby Company, 1960. Price, $12.00.

The reviewer failed to have the opportunity to examine the previous edition (1956) of this interesting and well-written book, but the current edition should be stimulating to many physicians in widely divergent fields, as well as dentists and geneticists. The author points out that the otologist, the ophthalmologist, the internist, and the hematologist see these patients, as well as the more acutely interested generalist, orthopedist, pediatrician and dermatologist, and they view such disorders as the Marfan syndrome, Hurler's disease, and other hereditary connective tissue entities from different diagnostic aspects.

A terminal chapter offers a good discussion of questionably inclusive diseases with such obtruse conditions as Leri's pleonosis among them.

The historical background of the various conditions is given more than usual emphasis, examples being observations as those noted under Osteogenesis Imperfecta, where "an early case was Ivar the Boneless, the master mind behind the Scandinavian invasion of England in the ninth century. He is said to have cartilage where his bones should have been. He could not walk on his legs and was carried into battle on shields."

The text is profusely and very well illustrated, extending through the gamut from autopsy material to x-rays. The chapter on Marfan's syndrome occupies 92 pages and is particularly good. Recommended to the many of us who have seen, but failed to diagnose, or properly advise.

A.A.H.

THE LIFE EXTENSION FOUNDATION GUIDE TO BETTER HEALTH. By Harry J. Johnson, M.F., President, The Life Extension Foundation. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1959. Price, $4.95.

This is an interesting book written for general public consumption. It is a guide to basic health care based on certain common sense rules of good health. It is derived from

the experience and knowledge accumulated by the Life Extension Examiners over a period slightly less than fifty years. It is written in plain spoken non-technical terminology. This group, whose avowed purpose is to "disseminate and apply knowledge of science of disease prevention" has, through its director, succeeded in an interesting presentation of health knowledge for the average reader. Well selected anecdotes are used successfully in putting across the various points. Brief summaries follow each chapter.

The book is well printed and the material is well presented.

R.W.B.

ADVANCES IN GYNECOLOGIC SURGERY. Edited by S. B. Gusberg, M.D.

CESAREAN SECTION. Edited by Edwin J. De Costa, M.D. Paul B. Hoeber, Inc. (Medical Book Department of Harper & Brothers), December, 1959. Price, $18 a year.

The December volume contains two excellent symposia dealing with Cesarean Section and Advances in Gynecologic Surgery, written by today's leading authorities. The indications, techniques, anesthesia, mortality and complications receive thorough discussion. A provocative section is included presenting the legal aspects of Postmortem Section. The experienced gynecologist will find little that is new in the surgical portion of the volume, but a pleasant review of progress in operability. This volume concludes with a complete outline of the newest concepts of the Gynecological Examination.

J.R.P.

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Reprinted from the *Pennsylvania Medical Journal*, November 1957-October 1958. By permission of the Commission on Cancer, The Medical Society of the State of Pennsylvania and the American Cancer Society, Pennsylvania Division, Inc.

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*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

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Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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